UTAH DEPARTMENT OF HUMAN SERVICES
STATE DIVISION OF SUBSTANCE ABUSE
AND MENTAL HEALTH

A FIELD GUIDE FOR COMMUNITY MENTAL HEALTH CENTER ADULT CASE MANAGERS

SECOND EDITION
March 2003
Salt Lake City, Utah

ACKNOWLEDGEMENTS

Thank you to the many agencies and persons who assisted in the compilation and writing of this case management guide. A special thanks to the following:

Janilyn Pierson, Bear River Mental Health
Melba Hill, Central Utah Counseling
Janell Black, Davis Behavioral Health
Denise Wiswell, Davis Behavioral Health
Robert Greenberg, Four Corners Community Behavioral Health
Robin Potochnick, Four Corners Community Behavioral Health
Robert Hall, Northeastern Counseling Center
Dan Rogers, San Juan Counseling Center
Lanita Adams, Southwest Center
Carlton Mangum, Southwest Center
Stephanie Volker, Southwest Center
Kathi Dunn, Wasatch Mental Health
Lisa Schumacher, Wasatch Mental Health
Patrick Cox, Weber Human Services
Kevin Eastman, Weber Human Services
Teryl Clark, Valley Mental Health
Kelli Olson, Valley Mental Health
Martha Anderson, Office of Consumer Affairs
Michelle Davis, Utah Division of Substance Abuse and Mental Health
Robert H. Snarr, Utah Division of Substance Abuse & Mental Health

Also, thank you to the many agencies and persons who assisted in the compilation and writing of the first edition of this case management field guide:
Four Corners Mental Health Case Management Project
Valley Mental Health
Ohio Department of Mental Health
University of Utah Graduate School of Social Work
Utah State Case Management Task Force
Utah State Division of Mental Health
Utah Legal Center for the Handicapped

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I. INTRODUCTION

Why a Case Management Field Guide?

This guidebook was written to help prepare you for one of the most important jobs in community mental health today. It will be a study guide as you prepare to take a formal exam required by the State Division of Substance Abuse and Mental Health to become a certified case manager and provide services. It will be a resource manual for you at the beginning of your training and a reference you can use.

This field guide is a companion in your work. Like any new textbook or course of study, this field guide should be considered just a beginning.

What are the Origins of Case Management and Community Support?

In Utah and in most other states, community mental health centers (CMHCs) are responsible for case management in their local areas. They develop cooperative working arrangements to provide resources and services not routinely provided in CMHCs, such as public benefits and employment training. Case managers provide the energy and organization to see that these plans result in real benefits to clients. They help clients develop goals and coordinate, advocate, link and monitor services, and help facilitate the achievement of goals.

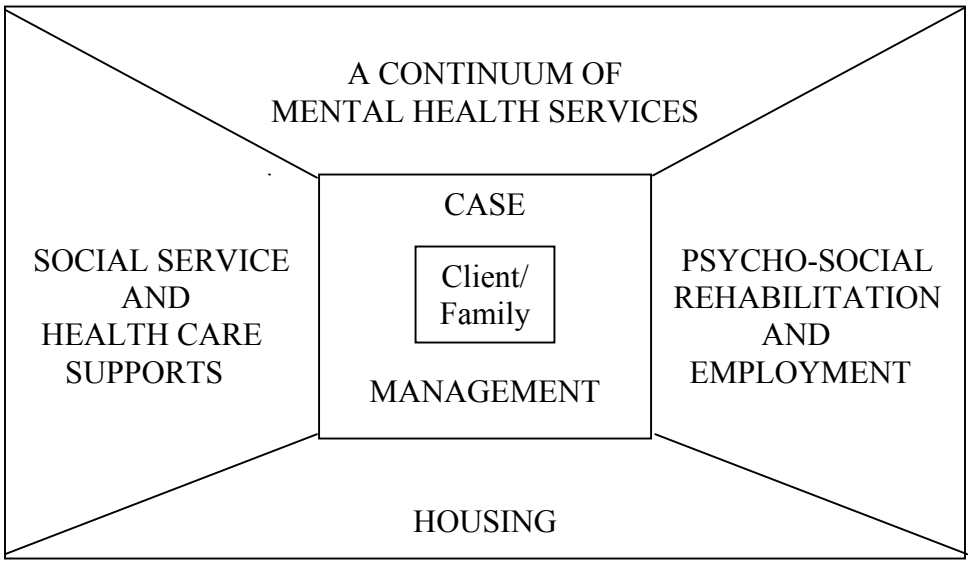
Historical Perspective

At one time people with serious and disabling mental illness received all of their treatment and the basic requirements of living within hospitals or asylums. During and after the "deinstitutionalization" movement of the 1960's and later, many people with mental illness in the United States became "ex-patients." Between 1965 and 1980, 358,000 residents of public mental health hospitals were discharged to live in the community. In addition, many people with mental illness were not admitted for long-term hospitalization. The focus of care and treatment shifted from the *institution* to the *community.* Many individuals with mental illness had neither the skills nor the resources to live satisfactorily in the community. Most community mental health workers lacked the knowledge, skills and attitudes necessary to help with such basic questions as where to live, how to get food and clothing and more. Case management was most often provided by families, other clients or not at all.

What is Case Management?

Case management is a method of helping clients get the services they need to achieve their goals.

Like other citizens, clients of mental health services are entitled to live as productively as possible and to receive the treatment they need with a minimum of interference and a maximum of support. A well-conceived case management service plan will match an individual client's strengths and needs to specific community resources. For many Utahns who rely on mental health services, a dedicated case manager can make the difference between isolation and productive community connections.



State of Utah Definition of Case Management

Case management is a process in which the client is a partner, to the greatest extent possible, in assessing needs, obtaining services, treatments and supports, and in preventing and managing crisis. The focus of the partnership is recovery and self-management of mental illness and life. The client and the case manager coordinate, advocate, link and monitor for services and supports directed toward the achievement of the individuals' personal goals for community living. Certified case managers include:

1. Licensed mental health professionals, including licensed physicians, licensed psychologists, licensed certified or clinical social workers, licensed social service workers, licensed registered nurses, licensed marriage and family therapists, or licensed professional counselors;

---Or---

2. Licensed practical nurses or non-licensed individuals who have met the State Division of Substance Abuse and Mental Health's certification standards for case managers, and who are supervised by one of the licensed mental health professionals identified in number (1) one.

II. WHO ARE THE CLIENTS OF CASE MANAGEMENT SERVICES?

Case management is support that assists persons with serious and persistent mental illness (SPMI) to optimize their adjustment in the community. In case management, one person, or a team of providers, assumes the management of the care of a person with a serious mental illness. Case management is usually done in the community as opposed to an office type setting and may be done in the client's home, place of employment, shelter, on the streets, in residential settings, etc. The frequency of contact between the case manager and the client is typically higher than the frequency of contact in a customary outpatient setting. The case managers provide continuity of care for the client in the mental health system and may also address psychosocial problems such as housing, transportation, application and attainment of entitlements, attainment of food, activities of daily living (ADLs), medical and psychiatric appointments, education, employment and other activities.

Presentation of Serious Mental Illness

Clients are generally referred to case management services because their mental illness has caused significant disruptive episodes in their life. Their symptoms may have lead to one or more hospitalizations or may have affected their ability to manage aspects of their life independently. They often require ongoing treatment with psychotropic medications and may need some level of assistance in other areas of their life. Often, the more episodes that a person has that lead to a severe disruption, the more difficulty they will have managing their life. So one important function of case managers, and other professionals as well, is providing sufficient monitoring so that the client experiencing an episode of their mental illness can referred to appropriate treatment as early as possible and hopefully prevent the episode from being so severe that hospitalization is needed. It is important that case managers be able to recognize symptoms and report the symptoms to their supervisor and/or the client's clinician. *However, case managers do not diagnose or provide mental health treatment.*

It is also important to remember that individuals with a serious mental illness are not symptomatic all the time. If not entirely symptom free, they may have a low level of symptoms but are able to manage them in such a way that it does not cause personal distress or a significant disruption in their daily life.

Case managers do not provide direct treatment for the mental illness. However, they are often in a unique position to monitor the client and observe early signs that a person may be "decompensating," or showing an increase in symptoms of their mental illness. Therefore, it is important for case managers to have some awareness of, and knowledge about, the various types of serious mental illnesses that our clients may have. Several of the most prominent disorders are highlighted in more detail on the following pages. In addition to the general information provided here, information on various disorders can be found in the DSM-IV-TR, the diagnostic manual used by clinicians. It is important to always consult with your supervisor and/or the client's clinician.

Psychotic Disorders

The common characteristics of these disorders are symptoms that center on problems of thinking. The most prominent (and problematic) symptoms are delusions or hallucinations. Delusions are false beliefs that significantly hinder a person's ability to function. For example, they may believe that people are trying to hurt them, or they may believe they are someone else (a CIA agent, God, etc.). Hallucinations are false perceptions. The most common hallucinations are auditory and are experienced by the client as "hearing voices." Other types include: olfactory (smelling), tactile (feeling sensations), taste, or visual (seeing things that are not there). Other symptoms that may be experienced include: disorganized or illogical speech, disorganized behavior, or negative symptoms such as affective flattening, social withdrawal, and decline in personal hygiene and grooming.

Types of Psychotic Disorders

Schizophrenia – This is one of the most common of the psychotic disorders and one of the most devastating in terms of the effect it has on a person's life. Symptoms may include the following: hallucinations, delusions, disorganized speech, grossly disorganized or catatonic behavior, social withdrawal, lack of interest, and poor hygiene. (Refer to the glossary for specific terms). The disorder has several specific types depending on what other symptoms the person experiences.

- Paranoid Type – There is a preoccupation with one or more delusions or frequent auditory hallucinations. These are often experienced as threatening to the person. With this type, the person *does not* experience prominent symptoms of disorganized speech, behavior, flat or inappropriate affect.
- Disorganized Type – There is a prominence of all of the following: disorganized speech, disorganized behavior, flat or inappropriate affect.
- Undifferentiated Type – A type in which the major symptoms are present but criteria for paranoid, disorganized, or catatonic types are not present.
- Catatonic Type – Characterized by significant motor problems such as immobility, excessive motor activity, peculiarities of movement, or echolalia, and mutism.
- Residual Type – Absence of the prominent symptoms of schizophrenia but some continuing evidence of the disturbance as indicated by the presence of negative symptoms of two of the prominent symptoms in an attenuated form (odd beliefs, unusual perceptual experiences).

Schizoaffective Disorder – Another psychotic disorder in which symptoms that meet the criteria for schizophrenia are present and during which, at some time, there is either a Major Depressive Episode, or a Mixed Episode concurrent with symptoms of schizophrenia.

Delusional Disorder – A psychotic disorder in which a person experiences a nonbizarre delusion for at least one month. This type of delusion involves a situation that could occur in real life (for example, being followed or watched, poisoned, loved at a distance, or having a spouse that is cheating on them).

Other psychotic disorders include: Brief Psychotic Disorder, Shared Psychotic Disorder, Psychotic Disorder Not Otherwise Specified, Psychotic Disorder Due to a General Medical Condition, and Substance Induced Psychotic Disorder.

Mood Disorders

The disorders in this category include those where the primary symptom is a disturbance in mood, where there may be inappropriate, exaggerated, or a limited range of feelings or emotions. Everyone gets down sometimes, and everybody experiences a sense of excitement or emotional pleasure. When a client has a mood disorder, feelings or emotions are to the extreme. Many clients with mood disorders function very well in outpatient settings though they may be hospitalized for brief periods.

Depression – Instead of just feeling down, the client might not be able to work or function at home, they might feel suicidal, lose their appetite, and feel very tired or fatigued. Other symptoms may include: loss of interest, weight changes, changes in sleep and appetite, feelings of worthlessness, loss of concentration, recurrent thoughts of death.

Mania – This includes feelings that would be more towards the opposite extreme. There might be an excess of energy where sleep was not needed for days at a time. The client may be feeling "on top of the world," and during this time, the client's decision- making process might be significantly impaired and expansive, they may experience irritability and have aggressive outbursts, although the client might think they were perfectly rational.

Bipolar – A person with Bipolar disorder cycles between episodes of mania and depression. These episodes are characterized by a distinct period of abnormally elevated, expansive, or irritable mood. Symptoms may include: inflated self-esteem or grandiosity, decreased need for sleep, more talkative than usual, flight of ideas or a feeling that their thoughts are racing, distractibility, increase in goal-directed activity, excessive involvement in pleasurable activities that have a high potential for painful consequences (sexual indiscretions, buying sprees, etc.).

Individual who have recurring manic episodes will frequently have a problem keeping jobs or having stable relationships. Their behavior may get them into financial trouble or even result in criminal charges. When experiencing mania, the person will often have great difficulty making decisions that are in their best interest. The depressive phase of this illness can also be quite devastating and if the depressive episode follows a manic episode, the contrast can be unbearable. Individuals with bipolar disorder can experience severe depressive symptoms and may at times be a significant risk for suicide.

Personality Disorders

Individuals with Personality Disorders have symptoms and personality traits that are enduring and play a major role in most, if not all, aspects of the person's life. These individuals have personality traits that are inflexible and cause impairment in social or occupational functioning or cause personal distress. Symptoms are evident in their thoughts (ways of looking at the world, thinking about self or others), emotions (appropriateness, intensity, and range), interpersonal functioning (relationships and interpersonal skills), and impulse control.

Personality disorders are listed in the DSM-IV-TR under three distinct areas, referred to as "clusters." The clusters are listed below with the types of symptoms or traits seen in that category and the specific personality disorders included in each cluster are also listed. For personality disorders that do not fit any of the specific disorders, the diagnosis of Personality Disorder NOS (not otherwise specified) is used.

- Cluster A – Hallmark traits of this cluster involve *odd or eccentric behavior.* It includes: Paranoid, Schizoid, and Schizotypal Personality Disorders.
- Cluster B – Hallmark traits of this cluster involve *dramatic, emotional, or erratic behavior.* It includes: Antisocial, Borderline, Histrionic, and Narcissistic Personality Disorders.
- Cluster C – Hallmark traits of this cluster involve *anxious, fearful behavior.* It includes: Avoidant, Dependent, Obsessive-Compulsive Personality Disorder.

Because of the way that individuals with Personality Disorders from Cluster B present, they are frequently referred for case management services. Many of these individuals have a dramatic presentation and exhibit a high level of use of services including hospitalization. It is important to do a careful needs assessment with these individuals to make sure their needs and requests are consistent with the Preferred Practice guidelines. It may be contraindicated to provide long-term supportive service, as that can foster a level of dependence that may not be needed. However, they may benefit from short term targeted services such as: referrals to vocational programs, assistance with paperwork for entitlement programs, etc. Personality Disorders offer a unique challenge. A thorough needs assessment and consulting with your supervisor is critical when providing services to individuals with Personality Disorders.

III. THE CASE MANAGEMENT PROCESS

Major Activities

Case management can be thought of as filling four critical functions. These functions are summarized below.

Coordinating with and for the Client

- Develop a long-term supportive relationship with the clients.
- Maintain regular contact with clients ranging from several times a day to once a month contact, depending upon client needs.
- Maintain contact with eligible clients no matter where they reside, i.e., homeless, hospital, jail, group home, independent apartment, etc., through *outreach*, taking the initiative to stay in touch.
- Provide case management services to eligible clients on a continuous basis, depending on the clients' needs.
- Discuss and develop a comprehensive service plan for and with each client based upon a needs assessment.

Advocating for Client Rights

- Work with clients to advocate for service improvements when services are judged unfair, inadequate or non-existent
- Assist clients in using formal grievance processes, starting at the local level and culminating with the State Division of Substance Abuse and Mental Health or Adult Protective Services, if necessary.
- Bring examples of unmet needs, and possible solutions for meeting such needs, to the attention of mental health decision-makers for their consideration for possible action.
- Encourage and assist clients to join any advocacy groups in their area or form groups where none exist.

Linking to Services

- Become knowledgeable about the community supports and resources available to clients such as public and private treatment providers, advocacy and self-help groups, low-income housing resources, employment and training programs, financial benefits, etc. Maintain regular contact with these groups to aid client access.
- Work with clients to:
    - — access appropriate treatment programs within local resources
    - — obtain all benefits for which they are eligible
    - — obtain a satisfactory living situation
    - — secure employment training and/or work opportunities and assist them in meeting employment goals

— obtain needed health care services as well as regularly scheduled physical examinations

- Assist clients in developing a range of social supports, i.e., client self-help groups, families, peers, etc.
- Encourage family members to get involved with organization such as the National Alliance for the Mentally Ill (NAMI), local affiliates and/or family support groups.
- Assist family members in accessing mental health and social services programs to meet their own needs.

Monitoring

- Follow-up and evaluate, with the client, to ensure that services are meeting their needs.
- Evaluate services, with the client, on an on-going basis to assess if the client can reach the goals of their service plan.

Each of these critical functions will be examined on the following pages.

Coordinating With and For Clients

The Relationship

A primary factor in being a successful case manager is the working relationship. In this respect, it is like a relationship between a therapist and a client. But it is different from this type of relationship in several other respects. *A good case management relationship is based upon trust, mutual respect and a willingness to work together to attain agreed-upon objectives. The primary target for change is not the individual, but the environment.* The case manager does not attempt to change the client's beliefs, values or emotions, but works with the client to improve living conditions. In doing this, the case manager can help the client increase his/her skills, and expand the individual's horizons. A strong partnership for advocacy, when it is conscientiously pursued over the long term, can change people as well as their environment. The case management relationship, like any other, thrives on consistency, regularity of contact, openness, honesty and the careful building of trust.

Obstacles: A variety of factors can make development of this relationship especially difficult. Sometimes clients find it difficult to develop this kind of connection due to a history of disappointments and rejections by agencies and institutions. Sometimes, particularly in rural areas, there are serious transportation and communication problems that prevent anything other than occasional or irregular contacts. In many instances, the client's illness has prevented the normal development of social skills or caused the individual to retreat into patterns of solitary living. The illness often interferes with effective communication, especially during an acute episode. Such periods can be disruptive and disturbing to the person and to others. These matters should be discussed and evaluated with the case management supervisor to consider the best kind of assistance for "weathering" this period.

Clear Communication: Sometimes clients have trouble separating what is real from what is not real (delusions, hallucinations or other mental abnormalities). They may be painfully sensitive. These factors can mean that the person does not receive clear signals from and about his/her environment and may not know the socially appropriate behaviors that go along with the situation. Case managers, family members and friends can confirm what is real. Any individual needs clear and accurate information about their world. This is especially true for clients who, for instance, hear "voices" that compete for attention with real voices and perceptions from the outside world. Case managers should consistently provide clear and accurate communications to the client about what is going on in the environment.

Another important aspect of consistency and reality testing in the case management relationship is that of setting limits and boundaries. It is important that these limits and boundaries be known and clear to the client and the case manager. Some limits originate with the CMHC policy or the Code of Conduct (see Preferred Practice Guidelines, Provider Code of Conduct, and National Association of Case Management ethical guidelines). These should be studied and understood by each case manager. Most limits and boundaries are maintained by sound judgment of the case manager. *Case managers must never under any circumstances, date or in any way encourage intimacy with clients.* They should not routinely receive phone calls at their homes or otherwise indirectly suggest that the professional relationship may become a personal one. Supervisors and other staff members should be used to help the case manager answer specific questions about this.

Case managers who were previously, or may still be clients, may have special problems in clarifying which role is appropriate. The client case manager can have special understanding and sympathy for the problems of clients, but that very strength might sometimes result in conflicting loyalties and misunderstandings. The client case manager needs to discuss these problems with his/her supervisor and know the specific expectations of the agency.

Clients, Not Cases: One of a case manager's strengths is the ability to see clients as ordinary people, not as "cases" or collections of mental health symptoms. They are people with certain skills and abilities and, like everybody, they have deficits that prevent them from reaching some of their goals. The case manager's job is to help them recognize and learn to adjust to those deficits so that they can live as fully and satisfactorily as possible.

When the focus is on abilities rather than disabilities, then the client is strengthened. The case manager must be aware of the danger of confusing his/her goals with those of the client. If this happens, the case manager and the client are bound to be frustrated and disappointed. Case managers do not impose their values and do not restrict the client's right to make their own decisions. Exceptions may occur with civil commitment. (See rules for civil commitment in S.B. 27 - http://www.le.state.ut.us/~2003/bills/sbillenr/sb0027.pdf)

Basic Value Assumptions and Ethical Guidelines

The case management approach to helping people with serious and persistent mental illness is anchored in the following value assumptions. The first and most central have just been described and are emphasized in a number of places here.

- The case manager/client relationship is primary and essential.
- The work of case management focuses on individual strengths and needs rather than illness.
- The work of case management is based upon the principle of client self-determination.
- Outreach to the client in his/her familiar circumstances is the preferred method of case management.
- Clients of mental health services can continue to learn, grow and change.
- The community is the primary resource to attaining the goals of the client.

Ethical Guidelines: Case managers need to be conscientious about providing services within local, state and federal laws, as well as general ethical practices. Issues of concern may include substance abuse, confidentiality, dual relationships, setting and maintaining appropriate boundaries, imposing own values, etc. Case managers need to refer to the CMHC policy and procedures, the provider code of conduct, the National Association of Case Management (NACM) ethical guidelines, and use supervision appropriately.

NACM Ethical Guidelines: As a Case Manager, I:

- Am committed to respect the dignity and autonomy of all persons and to behave in a manner that communicates this respect.

- Am committed to each individual's right to self-determination, and the rights of people to make their own life choices, and I am committed to embarking hopefully on a recovery journey with every person I serve, letting them direct their own healing process.

- Am committed to fight stigma wherever I find it, to educate the community, and to promote community integration for the people I serve.

- Do not allow my words or actions to reflect prejudice or discrimination regarding a person's race, culture, creed, gender or sexual orientation.

- Strive to both seek and provide culturally sensitive services for each person and to continually increase my cultural competence.

- Am committed to helping persons find or acknowledge their strengths and to use these strengths in their journey of recovery.

- Am committed to helping persons achieve maximum self-responsibility and to find and use services that promote increased knowledge, skills and competencies.

- Acknowledge the power of self-help and peer support and encourage participation in these activities with those I serve.

- Am honest with myself, my colleagues, the people I serve, and others involved in their care.

- Keep confidential all information entrusted to me by those I serve except when to do so puts the person or others at grave risk. I am obligated to explain the limits of confidentiality to the persons I serve at the beginning of our working together.

- Am committed to a holistic perspective, seeing each person I serve in the context of their family, friends, other significant people in their lives, their community, and their culture, and working within the context of this natural support system.

- Must strive to maintain healthy relationships with the people I serve, avoiding confusing or multiple relationships and keeping the relationship focused on the individual's needs, not my own.

- Maintain a commitment to prevent crisis situations with the people I serve, to present and support crisis alternatives, to develop an advanced instruction crisis plan with the individual whenever possible, and to avoid forced treatment unless there is a clear and present danger to the person served or another.

- Have an obligation to consult with my supervisor, obtain training, or refer to a more qualified case manager any individual with a need I do not feel capable of addressing.

- Have an obligation to remain curious; learning, growing, developing, and using opportunities for continuing education in my field or profession.

- Am committed to a regular assessment of my service recipients' expectations of me and to consistently improving my practice to meet their expectations.

- Have an obligation to advocate for the people I serve, for their rights, for equal treatment and for resources to meet their needs.

- Am obligated to learn the laws and regulations governing my practice and to abide by them, including the duty to warn anyone in danger of physical harm, and the duty to report physical, sexual, emotional and/or verbal abuse to the proper person or agency.

- Am obligated to work supportively with my colleagues and to keep their confidences.

- Am obligated to urge any colleague who appears impaired to seek help and, failing

this, to discuss my concerns with the appropriate agency authority.

Recovery

One of the important concepts in the field of mental health is the idea that people can recover from a mental illness, even the most severe illnesses such as schizophrenia and bipolar disorder. By recovery, we mean that the client is able to regain social roles and identities that are identified as valid by the client and the people in their community. It also means regaining rights and taking personal responsibility.

Key Concepts in Recovery:

- Hope – Clients need to feel they can get better and have a good life.
- Personal Responsibility – Clients need to feel they can control their own lives and take responsibility for their own care.
- Education – Clients need information about their illness and treatment options.
- Self-Advocacy – Clients need support from others, including family, peers, professionals, and the community.

Recovery often depends on the client finding someone who believes in him or her. When a case manager is able to take that type of supportive and encouraging role with a client, it is very powerful and can be instrumental in that client's success.

Work, Training and Jobs

In the past, rehabilitation and community mental health practice have often been seen as separate forms of helping clients; the former concerned with helping clients change behaviors and the latter concerned with helping them change thoughts and feelings. More recently, case management methods and values are helping to change this artificial separation between the "inside and outside" experience of clients. Each aspect influences the other. Most clients would choose to work, given the right work skills and abilities, and the appropriate work setting in which to use them. The individual needs assessment and the service plan should directly address the client's objectives involving work. Some key questions for clients and case managers are:

- Does the client have the skills and abilities to work successfully?
- How can he/she acquire skills and abilities and learn to apply them?
- How can the individual minimize disabilities or deficits?
- Where can the individual get a job in a sheltered or regular work environment?
- How will a job affect the client's benefits?

Each of these major questions deserves attention. Like other inseparable aspects of effective case management, the answers to these questions depend on many things including the values of the community, the client's skills and motivation, the availability of work, and the creativity and commitment of the case manager. You are not simply helping individuals to change, but helping organizations and institutions respond more effectively to their needs.

Some areas of Utah have a club program with transitional employment (TE) and supported employment (SE) available to members. If your agency does not offer a clubhouse model, TE, or SE, the responsibility of helping the client locate employment resources will fall to the case manager. TE, SE, and clubhouses offer social, recreational, educational, pre-vocational, and vocational opportunities to clients whom they call "members." Part-time and volunteer work can provide the same opportunities.

Rehabilitative Attitudes: The results of rehabilitation planning with clients are influenced greatly, and in some instances primarily, by the attitudes that the case manager, family members and other significant individuals have toward the client. Clients are very sensitive to signs of encouragement and signs of anticipated failure. This is true regardless of how symptomatic or ill the person is. The "can do" attitude can be contagious.

Basic Approaches to Vocational Rehabilitation of Mental Health Clients: There are two basic approaches to helping clients engage in the world of work. Each one attempts to effectively deal with the individual's experience of mental illness. The first approach may be termed adjustment to disability.

An example of this approach is the sheltered workshop that adjusts the tasks, the length of work time and the compensation to an individual's presumed capacity for the demands of work. Basically, this involves fewer requirements for disabled workers and according to certain guidelines, less pay. Other volunteer jobs can be found and tailored to the limitations of the disability. Some people with mental illness find this kind of situation quite satisfactory for them. These environments are necessarily very tolerant of the symptoms and idiosyncrasies of individuals.

The second approach to helping people with mental illness involves an adjustment to the job. This simply means that the anticipated job requires a certain level of cooperation with peers and supervisors, appropriate dress and grooming, punctuality, regular attendance and job specific skills. This approach does not allow for the job to be partially or poorly done nor does it allow for deviance from ordinary demands for social skills in that setting. The strength of this approach is that it is a real job and success, even partial success, can give a tremendous boost to the client's self-image. Perhaps the greatest remedy for low self-esteem that accompanies mental illness is the opportunity for the client to escape endless "patienthood." Doing a job and being a worker means being normal in spite of mental illness. Getting into competitive employment is a great success and should be "celebrated" with a client like other victories of case management. Attempts at employment that do not work out should be viewed as opportunities to learn. Always help the client weather through failed attempts at employment and adjust plans to enable a greater likelihood of success next time.

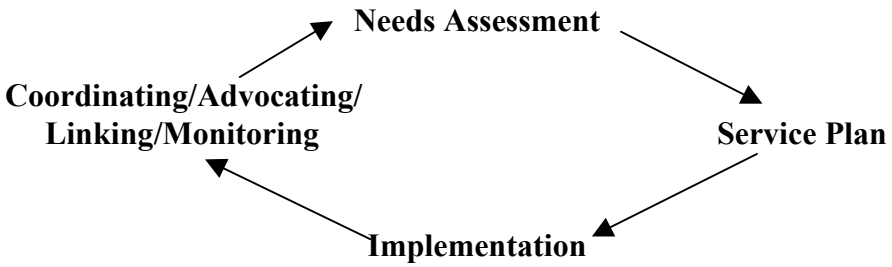
Assistance with Client Employment Problems: In Utah, you may contact your nearest office of the State Vocational Rehabilitation Services. They can help with work assessment and training.

Many local mental health/substance abuse authorities have their own programs within their geographical area. Each local authority is different with approaches to offering supported employment programs. Contact a supervisor or administrator at your agency to learn about resources available.

Planning for Services: The Needs Assessment

In order to determine what services the client needs, an evaluation is necessary. This evaluation is called a needs assessment. Once this assessment is made, a service plan is developed which outlines long-term goals and the smaller steps that must be taken to achieve those goals.

The Case Management Process



What is a Needs Assessment?

- A tool to obtain and represent the ongoing growth and needs of the client.
- A needs assessment of the person's situation and circumstances include:
  - behaviors indicating danger to self or others
  - benefits/financial resources
  - crisis incidents
  - daily living skills (ADL's)
  - housing
  - interpersonal and social relationships
  - medical/health needs
  - legal
  - medication compliance
  - mental health services/substance abuse
  - transportation
  - treatment participation
  - vocational/educational
- The following questions may help guide the needs assessment process when meeting with the client:

- What kind of experience has the client had up to this time?
- What is going on now for the client?
- Where would the client like to be?
- What resources can he/she use to make the desired changes? What talents or experience can the client use to meet the desired goals?
- What steps does he/she need to take to make the changes? What is the most important at this time?

- The needs assessment is an ongoing working document and is to be updated when the client's status is altered, goals change, or new resources are acquired. This assessment is to be reviewed at least every 180 days.

Developing a Needs Assessment

There are main areas that should be incorporated into the case management needs assessment. These will include assessing and documenting the client's need for community resources and services. Assessment and services should build upon the assets, strengths, and capacities of clients in order to help them maintain a sense of identity, dignity and self-esteem. The procedure should be natural and flexible. Some important principles that apply to all areas are:

- Start where the client is. An adult-to-adult relationship accentuates and models effective communication.
- Focus on strengths.
- Select a comfortable environment to conduct the needs assessment.
- All of the need areas should be addressed and prioritized, as per the client's ability to participate.
- Ask open-ended questions.
- Involve family members and other significant social resources and natural supports in the process with the client's release of information.

Introduction and Exploration: In this initial phase, the case manager will introduce himself/herself to the client. They will explain the case management process and the goals of this service. The case manager will begin to evaluate the client's current level of engagement. It should be kept in mind that willingness to participate in case management services is closely associated with client choice. Persons may be temporarily satisfied with their lives and circumstances, not desiring to begin work on more progressive goals and objectives. Willingness must be cautiously evaluated by case managers and must not be used as an excuse for under-serving the client. In this phase, the case manager will also explore the client's community and unique situation with respect to present and future needs, past experiences, interests, aspirations and current or previously used skills and resources.

Empowerment and Acceptance: The client is the "expert" about their own unique strengths, interests, and aspirations. Case managers can positively influence willingness by

fostering hope and belief in the person receiving services. Services and needs assessments should incorporate client self-help approaches, and should be provided in a manner that allows clients to retain the greatest possible control over their own lives. As much as possible, clients set their own goals, decide what services they will receive and are active participants in the needs assessment, service plan development and the services provided. This principle allows the client to share in the recovery process to the greatest extent possible.

Active listening, reflection and verbal support are critical to the acceptance and empowerment of the client. In this process the case manager may respond to the information presented by the client by restating what he/she has heard the client say. The client is encouraged to explore their situation to identify their own personal strengths. For example, "You said you'd like to live in an apartment; tell me what kinds of things you can do to live on your own."

The Needs Assessment Discussion: The case manager responds to the client by moving in whatever sequence is natural throughout the discussion. It could begin with living arrangements and then move to finances. There is no prescribed sequence. The responses of the client are used to determine their level of need in the needs assessment. It is important to collect and record details regarding client responses. This information can then be incorporated into the needs assessment.

Since a needs assessment is ongoing, the case manager may stop the process at any point in order to:

- respond to a client's restlessness or unwillingness to continue
- to start the prioritization of needs to move into the development of a service plan
- to set a continuation date/time to gather further information prior to developing service plan

Prioritizing Needs

After completing the needs assessment, the client and case manager must identify which areas should be chosen as priorities for goal setting. These are first based on critical survival needs (food, shelter, clothing, medical care) and then less critical needs. Once the needs have been prioritized, the client and case manager are ready to develop a service plan to accomplish one or more of the goals.

The Service Plan: Development and Implementation

Once a needs assessment is complete, the identified goals of the client are recorded in a service plan.

What is a Service Plan?

A service plan is a set of action steps designed to achieve one or more of the client's goals as stated during the needs assessment. It is a plan that contains:

- short term goals or action steps
- long term goals
- parameters of service delivery
- review date
- signatures of the client, case manager and supervisor, if needed

Just as the needs assessment is completed based upon the individual client, so is the service plan. Consequently, there are given guidelines for completing the plan, but the design and emphasis of the plan is based upon the individual client.

The Role of the Case Manager in Designing a Service Plan

The role of the case manager is to assist the client to prioritize his/her needs, establish a goal statement(s) from his/her needs assessment, identify the necessary action steps to accomplish the goal(s) and to design a plan that will support the client progress. Throughout this process the case manager educates and reinforces the client's right and responsibility to identify and make choices. Many clients have such low self-esteem that they feel unable to make important choices for themselves. The case management process should help them reclaim some confidence in their ability to choose.

Each goal must be broken down into a set of action steps. These steps are listed along with who, how and when the step will be accomplished. The art of designing a personal plan is to develop action steps that are small enough, and a plan of support large enough, so that disappointments and failures are minimized.

The following is a checklist for writing quality action steps:

- Are the action steps stated in positive terms?
- Are the action steps realistic and achievable?
- Are the action steps observable and behavioral?
- Are the action steps stated in specific terms, not global terms?
- Are the action steps client oriented, not case manager oriented?
- Is the initial action step immediate with a high probability of success?
- Are the action steps set in sequential order and serve to accomplish a short-term goal?
- Are the number of action steps small enough to not overwhelm the client, but large enough to set a direction and set a challenge?

Once the needs assessment has resulted in a specific, time-limited service plan, the case manager and the client begin the exciting process of implementing the plan. Remember that

nobody's life can be traced by a straight line! Expect that the plan will need to be changed and revised from time to time.

Implementing the Service Plan

The next step is implementation. Now together the case manager and client will utilize resources from the community and the CMHC. The case manager will offer both practical support and encouragement throughout this process.

Offering Support to the Client

The most frequently expressed concern of new case managers is the perceived lack of progress of clients. The "revolving door syndrome," often addressed in literature and expressed in the field, describes clients who are discharged from the hospital into the community, then sent back to the hospital, only to begin the process again. It must be emphasized that the definition of a good case manager does not rest on client change. The ultimate attainment of client-based goals rests with the client, but the case manager and an active case management system are key players in eliminating obstacles to the client's progress. Growth and movement are supported by:

Celebrating Small Steps: Each time a client completes an action step a celebration is in order. The celebration may be as simple as acknowledging the success with direct eye contact and a verbal, "Good job, you did it."

Asking the Client How You Can Help: Helping a client attain goals requires just the right amount and kind of assistance. Sometimes helping can be unhelpful if it conveys a message of incompetence or unworthiness. The case manager's job is to help in a way that strengthens the client and the relationship.

Staying in Touch: Depending on the resources of each CMHC, the client can generally make contact with a member of the case management team or another mental health professional 24 hours a day. Of course, the case manager is not on duty 24 hours a day. However, staying in touch often means following the client both into and out of crises, acute care and long term hospitalization. Active outreach to the client is a cornerstone of case management.

Go With the Flow: A case manager must support changes in client choice even it involves more time and energy in paperwork. Completing the small action steps, celebrating successes, building community supporters, rehearsing a problem solving process, and having someone they trust to help them survive in the community are the real goals. "'Going with the flow" requires not only patience but also a clear understanding of case management and a true commitment to serving clients.

Advocating for Clients

In the role of an advocate, the case manager attempts to bring about solutions to problems impeding the client's progress or infringing on his/her rights. The case manager also teaches the

client to be a strong advocate for themselves. Additionally, the case manager develops a network of community collaborators for advocacy. Community collaborators are resourceful, caring, and responsible individuals who are committed to the growth and development of the client. Often these collaborators are family members, friends, neighbors, and community agency personnel. By meeting regularly with the client and with collaborators, barriers to client progress can be identified and steps can be taken.

- The case manager and the client must always have a clear understanding of what the problem is. As an advocate, the case manager's primary role is to help another the client to obtain what he or she wants. Case managers must not substitute their own ideas of "what is best" for clients.
- The case manager respects the dignity, self-worth and self-determination of the clients and, in all ways, attempts to enhance them.
- The case manager supplies the client, to the best of his/her ability, with tools required for the client to exercise control over his/her destiny.

Advocacy takes place at different levels of the service system. For example, the case manager may go with the client to reapply or submit an appeal for financial assistance, or a case manager may approach a public housing authority about developing low-income housing in rural areas. Advocacy is important. Through the process of case management, positive and long-term improvements for the clients can be made.

It is important to remember that clients are, in a real sense, your customers. They are customers of CMHCs, housing programs, rehabilitation agencies and all the services and organizations that comprise the community support network. As customers, paying directly for services or authorizing payment from government sources, clients have the right to be treated fairly, competently and with dignity from any services provider. Clients have the right to equal treatment regardless of their age, sex, race or ethnic origin. They have the right to have communication with therapists held in strict confidence, except for a few specific exceptions, and they have the right to participate in the development and review of their service plan goals and methods. Their rights may need to be asserted through administrative or legal appeal.

Grievance procedures refer to accepted administrative methods of solving problems or registering complains. Mental health institutions and agencies should have grievance procedures clearly stated and have them publicly posted. Any client has the right to know what these procedures are and to utilize them without fear of punishment. As a case manager, you may assist a client in using the grievance procedures of an agency. For routine complaints or concerns, clients can get administrative help with problems by speaking to a primary therapist or their case manager. If this is not possible, they can speak directly to the supervisor, program manager or consumer affairs. Ultimately, the agency director can be contacted as well as the State Division of Substance Abuse and Mental Health. If administrative remedies are used and the results are unsatisfactory, a person may contact a private attorney or the Disability Law Center (http://www.disabilitylawcenter.org/). Situations in which a client may have been abused or seriously neglected require immediate attention. (See Abuse and Neglect Reporting Law)

There are a number of active independent advocacy organizations in the state of Utah and they are listed in the Appendices. Some of the most powerful advocacy performed is provided by family members and clients themselves.

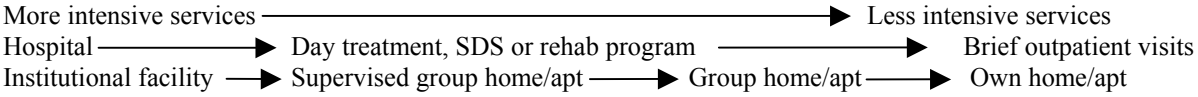
Linking the Client to Services

Because a crucial task of the case manager is linking clients with resources, the case manager must be familiar with the resources and key contact persons within particular agencies. This field guide can help you become generally acquainted with state and local resources. (See Appendix B)

Community Mental Health Center

It will be helpful for you to view CMHC services as a continuum. (See illustration below.) The continuum allows a client to receive services according to his/her need. If the person's behavior is fairly stable and functional, he/she may only need outpatient services. But if his/her behavior is more volatile or out of control, he/she may need to use more intensive services.

Continuum of Services



Outpatient services: These are individual or group counseling services provided by mental health professionals. These may involve discussing problems and solutions, providing emotional support, building relationship skills, and evaluating progress. These services include counseling for individuals, couples and/or families.

Emergency Services: These services are provided 24 hours a day for clients who are in crisis. Examples of such crises may include individuals who are experiencing suicidal thoughts, sudden attacks of anxiety or the death of someone important to them.

Day Treatment/Skills Development Services (SDS)/Psychosocial Rehabilitation: These services are provided daily for persons who need work, educational or social opportunities. The purpose is commonly to help the client develop daily living skills such as, how to budget and prepare for employment, through classes, group therapy, individual skills development, and social activities.

Medication Management: This service is provided by nurses, advanced practice registered nurses, and psychiatrists. Psychotropic medications are prescribed to clients while the effectiveness of the medications is monitored by both the psychiatrist and psychiatric nurses.

Hospitalization: When a client's symptoms become so severe that they are a substantial danger either to themselves or to others, the client is generally hospitalized. The hospital provides a safe, secure environment where the client receives treatment that is more intensive. If a person needs more extensive services, he or she will usually be referred to the Utah State Hospital (USH). Each CMHC has a liaison with USH who will participate in the discharge planning. Utah State policy requires CMHCs to take responsibility for all clients from their geographic area who are hospitalized at the USH.

Housing: There can be a range of housing services offered by the CMHC that is referred to as Housing/In Home Skills that provides treatment based, supportive and independent housing options to provide stability according to the client's level of need. For all housing associated with the center, there are admission and discharge criteria that the case manager will need to know. For housing in the community, case managers need to become aware of both public and private resources, for example, the local public housing authority.

Protective Payee Arrangements: Sometimes it will be determined that a client is unable to handle their own finances and a protective payee will be appointed. Often the mental health agency becomes the protective payee.

Public Entitlement Programs

Most people with long-term psychiatric disabilities need assistance to obtain entitlements. The most important kinds of assistance required are income support (SSI, SSDI, GA or TANF) and special services for people without money, such as donated medical or legal assistance. In most communities, the public and private social welfare system is fragmented, restrictive and characterized by complex intake and reporting procedures. A case manager can assist the client to gain access to public entitlements. It is also the case manager's responsibility to know the eligibility process.

Often, applicants for social security benefits are turned down the first time they apply for it but they are eligible to appeal that decision. Clients should not hesitate to appeal unfavorable decisions. To obtain state entitlements such as General Assistance (GA) or Temporary Aid to Needy Families (TANF), applicants will need to provide the following:

1) Birth certificate or a church or tribal record of birth
2) Picture identification (Driver's License or Utah State ID Card)
3) Social Security card

Additional information may be required including rent payments, bank balances, or insurance policies depending upon the situation. Clients must have the above documents to successfully complete an application for state assistance.

Federally Administered Entitlement Programs:

Medicare - Medicare is a federal health insurance program. Individuals who are 65 or older and those that receive SSDI benefits are automatically eligible for Medicare after they have received SSDI checks for twenty-four months.

Social Security Administration-Disability Insurance (SSDI) -This is a federally funded insurance program for the blind and disabled, funded by deductions from the applicant's payroll wages. Eligibility is based upon medical documentation of a disabling physical or mental illness. As with other insurance programs, a person must have contributed to it to receive payments later.

Supplementary Security Income (SSI) - This is a federal benefits program for the needy, aged, blind, and disabled. Eligibility is based upon medical documentation of a disabling physical or mental illness together with financial need. A thorough medical assessment and diagnosis with laboratory findings and other supporting evidence is required to support a successful application. It is in the client's best interest to appeal any findings of ineligibility, particularly at the first step. Entitlements are retroactive to the original date of application. The Disability Law Center can assist eligible clients with the appeal process.

State Administered Entitlement Programs:

Medicaid - This is a federal program to help low-income citizens with disabilities obtain medical care. Clients who qualify for SSI also qualify for Medicaid, but they must apply for each program separately. Not all providers of medical service accept Medicaid, so you will need to become familiar with the providers in your area who accept this insurance. If a client earns money or receives SSDI, they may have to pay for this benefit, depending on their income, which is referred to as a spend-down. Some CMHCs assist the client in paying the spend-down.

General Assistance (GA) - This is a basic state financial help for individuals who have not qualified for federal assistance programs such as Social Security and/or who have a short-term disability. Applicants must provide a completed medical form from a physician that describes the extent, duration and medical diagnosis of the applicant's claimed disability. Applicants found ineligible for General Assistance may ask to enroll in a state sponsored emergency employment program.

Limited medical coverage (Primary Care Network) is available as a state alternative to federal Medicaid coverage for clients who qualify for General Assistance. The state medical coverage, Utah Medical Assistance Program (UMAP) is a less extensive resource than Medicaid, particularly concerning long-term psychiatric disabilities.

Temporary Assistance to Needy Families (TANF) - This program is designed to meet the subsistence needs of children through payments to parents. Application for this program is by completing the same state application form used for all state cash, medical or food stamp

programs. Clients have the right to special assistance, foreign language translators or signers to complete the application process.

Horizon Card - Food stamps, now distributed as the Horizon Card, are used to supplement General Assistance. In emergency situations, they can be authorized and obtained within three days of application. Clients may apply for the Horizon Card and others forms of state assistance at the nearest Utah Department of Workforce Services.

Day Care - The State of Utah licenses day care providers to provide childcare to eligible parents. Many times clients will be eligible to use these services while they attend day treatment, participate in vocational training, etc. These services are also available from the Department of Workforce Services.

Community Resources

Besides the CMHC, each community has a variety of other services that will be crucial in assisting the client in fulfilling his/her goals. It is the responsibility of each case manager to learn the resources in their community that are beneficial to their clients and to assist the client in accessing and utilizing these community resources.

Monitoring

Monitoring involves reviewing the service plan to make sure it is being properly implemented and continues to fit the needs of the client. Monitoring also involves consistent help to the client in identifying problems, modifying plans, ensuring the client has resources to complete goals, and in some cases monitoring treatment compliance of the client. For example, there may be a need for a special medication check or a revised apartment rental agreement. Occasionally, monitoring could also include a client needing more intensive service, such as hospitalization.

Case management is a fluid activity; case managers are community bound, not office based. To monitor service delivery, the case manager must actively watch, listen and interact with both the client and all the service providers. Monitoring must occur while the client is participating in services and programs. Monitoring involves being with the client in his/her natural surroundings as well as the treatment environments. Therefore the case manager might be at one of many locations – the client's home, any office of a service provider, a restaurant in the client's neighborhood or a clubhouse, to name a few. Case managers often receive the most current and reliable information if they make first-hand observations. Also, to be effective, case managers must develop solid working relationships with both clients and service providers.

When the case manager is monitoring a client's progress towards meeting the service plan goals, he or she will be attempting to answer these questions:

1. Is the client getting the services established by the service plan?
2. Are the services provided in such a way that the client can benefit from them?
3. Are the services provided to the client meeting the objectives of the service plan?

4. Are the services provided in a manner that is beneficial or usable to the client?
5. Are the plans objectives appropriate to the client's current needs, skills, and abilities?
6. Will meeting the plan's objectives give the client the ability to continue living in the community?
7. Does the client need additional services or intervention to be able to continue making progress?

The questions point to the effectiveness of the services and the appropriateness of the service plan. The answer to the questions will lead to the next action. And if the current service plan is not helping the client, a revised assessment and service plan may be in order.

Managing Day By Day

It is impossible to anticipate all the problems that might be encountered in case management work but certain problems seem to arise frequently. These include monitoring medications, personal money management, transportation, personal hygiene, medical and dental care, and employment training and opportunities. These will be addressed briefly below.

Medication Management: For many clients, medical evaluation, prescription and management is the essential form of help in preventing the recurrence of primary symptoms of mental illness, such as auditory hallucinations or voices. These medications, also called psychiatric medications or psychotropic medications, work to stabilize brain functioning, diminish anxiety and reduce the flood of disturbing mental messages that clients can experience. These medicines do not cure mental illness, but they can help control symptoms.

The evaluation, prescription and monitoring of psychiatric medicine are all the responsibility of the prescriber affiliated with each client. Prescribers include psychiatrists, APRNs and medical doctors. Part of that responsibility involves discussing the need for medication, its effects and its side effects with each patient. However, the case manager can monitor a client's compliance with the medication regimen and report compliance to the rest of the treatment team. Case managers can advocate for the client in setting appointments, requesting an unscheduled appointment with the physician or helping the client to get prescriptions filled.

Many clients view medications as helpful and they are anxious to collaborate with medical staff to maximize the most effective use of medication. Others resist the use of medication, some forget to take their medications, and some stop because they feel better without it or dislike uncomfortable side effects.

Psychiatric medicines are powerful medications. They can mean the difference between a person's ability to live in the community or the need to return to the hospital. They do not substitute for housing, income, social and work connections in the community. But often, psychiatric medicines suppress or eliminate the symptoms of the mental illness that would otherwise block the individual's opportunities for more normal daily living.

Case managers must remember that clients have the right to treatment and the right to refuse treatment, including medication. Except under very special circumstances, clients, like other citizens, have the right to do things that in the view of others are not good for them. Each case manager should discuss problems with medication compliance with the treatment team. A basic knowledge of psychiatric medicines will help case managers appreciate why clients take them, and sometimes refuse to take them. Case managers can consult with prescribers about medications.

Psychiatric medicines can be examined in categories. First, anti-anxiety agents are intended, as the term suggests, to diminish extreme and debilitating anxiety. They are also referred to as minor tranquilizers. Second, anti-psychotics or major tranquilizers work to correct mental distortions of reality such as hallucinations. Anti-depressants are intended to relieve extreme feelings of despair and hopelessness that can sometimes lead to thoughts of suicide. Anti-Parkinson agents or side-effect medications attempt to control, diminish or eliminate the so-called side effects that can accompany the use of psychiatric medicines. These medicines, their properties and their uses are the special responsibility of medically trained and certified personnel. Some commonly used medicines, their uses and effects are listed in the Appendices.

Personal Money Management: Often a crucial area of case management is helping the client budget his or her financial resources. Living independently means new financial responsibilities that require self-discipline and saving for long-term purchases. Some suggestions to help case managers with budgeting are:

- Work with the clients to develop a list of priorities by helping them distinguish between needs and wants. Help them understand that money for the wants should come after the needs are taken care of.
- *DO NOT* push your judgments or values about money on to the client.
- Be careful to not "rescue." Work with the client to outline possible consequences (both positive and negative) for financial decisions.
- *DO NOT* use budgeting as a means of manipulation or punishment.
- Be aware of ethical concerns when dealing with clients on financial issues and consult with your supervisor.

Some clients will require a protective payee to manage their money. You, as the case manger, may be assigned this responsibility. Here are some additional guidelines if this is the situation:

- Continuously review the need for Protective Payee. Remember that a basic value of case management is to help clients be independent and gain more control over their own affairs. Encourage them to manage their own money as soon as possible.
- Know your agency policies and procedures about Protective Payee.
- Know the rules and regulations from Social Security about Protective Payee.
- Make sure to plan for holidays and vacations of staff. Clients should be able to receive their payments in spite of staff absences or agency closings.

Transportation: As a case manager, often one of your duties will be to transport clients. Some points to keep in mind are:

- If you are able to drive personal vehicles for case management, check with your agency and your own personal insurance company to ensure proper coverage.
- Know and follow your agency policies about transporting clients. Discuss these policies with your supervisor.
- *DO NOT* transport clients alone whom you believe are a safety concern.

Hygiene and Grooming: Adequate hygiene and grooming are problems for many clients. Case managers must carefully assess hygiene needs being careful to not push their own values on clients. DO NOT tell a client they need to "get a haircut" or "clean up." People with a mental illness, like other people, do not respond positively to accusations or inferences that they are dirty or unattractive. Advice like this will most often result in hurt feelings and will fail to change behavior. Intervention by the case manager should be preceded by a nonjudgmental and thoughtful assessment of the possible reasons for poor hygiene and grooming, health concerns associated with hygiene issues for the client and others, and ways to help with these problems.

What are some of the reasons behind these problems? The most obvious answer to this is a lack of money. People living on fixed incomes from government benefits often prioritize their spending to include many other needs before hygiene needs. Often they purchase second-hand clothes or accept donations of used clothes to conserve their monies. Second, they attend to other more pressing concerns, including their symptoms. Third, laundromats may not be easily accessible and they are always expensive. Fourth, they may not have anything or anybody for whom to clean up or dress up. They may see no reason to improve hygiene and grooming. Finally, poor grooming and hygiene often reflects the low self-esteem that commonly accompanies mental illness.

A major goal of the case management relationship may be to help the client discover resources and develop good reasons for caring about his/her appearance and hygiene. Occasionally, hygiene problems may directly threaten personal health or the health of others such as children. In such situations, case managers must take reasonable steps to insure health and safety, and consult with their supervisor.

Medical and Dental Care: Adequate, timely medical and dental care is often a problem for clients. Again, a common obstacle is poverty, not necessarily mental illness. Clients attempting to qualify for entitlements will find that certain illnesses and disabilities are covered while others are beyond their means. Exactly what benefits a person is entitled to is a matter that is individually determined. Case managers need to stay educated on the rules of benefits as they change frequently. The case manager needs to know or find out what medical and dental care can be obtained for the individual client and from where. Sometimes low-cost or no-cost services can be obtained for needy individuals from local professional or service organizations or from colleges or universities in your area.

Families of clients and other clients are often invaluable resources to individual clients and to the case manager. They know the history of mental and physical health problems, the

treatments and responses. They may be able to propose approaches that have worked in the past. Families can be a resource in managing these needs and case managers are encouraged to work with the family to manage client's needs.

IV. SPECIAL PROBLEMS

Crisis Intervention

Knowledge of crisis important for case managers in the event of a suicide threat and non-lethal problems such as eviction, divorce, or death of a loved one. A crisis is not necessarily a bad or destructive thing and the case manager can help the client understand and even benefit from many apparent crises of daily living. An individual crisis, such as the loss of a job, may ultimately have a positive outcome in that it helps the person to learn and grow. The case manager should consult with their supervisor and other team members to help identify what is happening in a given situation and to plan appropriate interventions when encountering a crisis situation.

Problem Behaviors That May Precipitate a Crisis

Popular culture and the media have portrayed people with a mental illness as violent and unpredictable. These false images of people with a mentally illness perpetuate the stigma and deepen the feelings of isolation and low self-worth already carried by many clients. The fact is that seriously and persistently mentally ill individuals who are taking their medication are no more dangerous than the general population. People who have been or are being treated for mental illness are usually anxious, timid, and passive. They are far more likely to be the victims of violence than to be the perpetrator. Most clients are quiet, responsible citizens who share the predominant values of their home communities. However, people with mental illness who are not taking their medication can be more dangerous than the general population. Factors such as substance abuse, medication noncompliance, and low insight into the illness operate together to increase violence risk. However, individuals with serious mental illnesses probably are responsible for no more than five percent of violent episodes in the United States.

Sometimes some clients do act against property, other people, or more commonly, themselves. This may involve willful law breaking or impulsive reactions to stressful situations or their own thoughts and feelings. It is impossible for anyone, including mental health professionals, to reliably predict how someone else is going to behave. There are guidelines that can help you respond helpfully and safely to these types of situations. The following sections describe some different categories of problematic behaviors along with suggestions for ways to respond.

Illegal Behaviors

Behaviors that are illegal for one citizen are also against the law for every other citizen. It is not the case manager's job to protect clients from the consequences of their own behavior. The motives behind criminal acts, whether sane or not, are a matter for legal authorities to determine. All case managers and clients should understand that the police should be notified when the law is broken.

Alcohol and Street Drug Use

Clients will sometimes choose to use alcohol and/or street drugs for a variety of reasons. Adult clients are free to use alcohol in accordance with applicable laws in their communities. However, they should be informed of the dangers usually associated with both drug and alcohol use, along with the possibility of dangerous interactions that these substances may have with psychiatric medications. Clients will sometimes stop taking their prescribed medication and prefer to "self-medicate" with alcohol or street drugs to relieve their symptoms, preferring these substances to their prescribed medication and the accompanying side effects. The case manager can provide the client with accurate and correct information upon which to make decisions. However, the client will not always make good decisions regarding substance abuse.

The case manager can monitor and assess the client for substance use and link them to public and private treatment programs and facilities, when appropriate. The case manager should inform the client's clinician of the client's substance abuse. A list of treatment programs for substance abuse is maintained by the Utah Division of Substance Abuse and Mental Health and can be accessed online at www.hsdsa.utah.gov.

Threatening, Violent or Homicidal Behavior

When someone's life or well-being is threatened, endangered, or violated, the case manager should initiate several actions. First, imminent or immediate threats must be respected for what they are—a potentially dangerous situation. Immediately reduce the threat if possible by withdrawing, leaving, or removing whatever may be causing the anxiety, agitation, or fear. Speak in a normal tone and a calming voice to the client. Ask for and provide verbal clarification of the situation. Avoid "trapping," "backing someone into a corner," or getting too close to someone if they are frightened unless it is specifically requested. Leave all exits open. If the danger does not diminish, then physically remove yourself and others from the situation and contact the police. The law requires that you inform anyone who has been threatened by another that his or her safety is jeopardized and by whom. Utah state law also specifically requires all mental health personnel to report known or suspected situations of child or adult abuse to the appropriate authorities. (See Appendices). You should never hesitate to call the police for assistance when you perceive an immediate threat to the physical safety of an individual. It is the job of the police, not the case manager, to physically restrain people who are out of control.

Situations involving potential harm to person or property should always be discussed with your supervisor at the earliest possible time so that plans can be implemented to protect the safety of the client, the case manager, and others in the community. These types of situations should also be carefully documented in the case management record.

Suicidal Thoughts and Behaviors

Suicidal thoughts and behaviors are fairly common with clients who are struggling with the symptoms of their mental illness and who may also lack the connections of work, family, and

friends to provide support during the difficult time. Thoughts of suicide may arise from desperation and discouragement or more rarely may result from "command hallucinations." Command hallucinations are "voices" instructing the individual to harm his/herself (or others) or take his/her own life during a psychotic episode.

All suicide threats must be taken seriously. It is essential that you consult with your supervisor and remain in close contact with your supervisor throughout the danger period. Safety is the number one priority during these times. Case managers should ensure that clients are aware of the availability of 24-hour crisis services in their area and know how to access these services when needed. This information should be reviewed with the client, and with the client's treatment provider, on a regular basis.

V. TAKING CARE OF YOURSELF

Working with people can be stressful. Working with persons who are poor and who suffer from mental illness can be even more stressful. It is important to take care of yourself – physically, emotionally, and socially. You may have opportunities to attend time management and stress management workshops. They will go into more detail about coping with the challenges of your job. But here is a list of suggestions that may be useful.

Time Management

- Make a daily plan of tasks.
- Prioritize the list. Identify those tasks that have to be done today (A's) from those which should be done, but could be done tomorrow (B's) and those which are not that important (C's).
- Be sure to do your "A" tasks first.
- Keep lists simple and realistic.
- Carry your list with you – consult it often.
- Let your list be your guide, not a ball and chain. You will find that you often have to adapt and revise.
- Let the clients know when you will have time to provide transportation, go shopping, etc. Set appointments with them and stick with it. If they are not there for the appointment, make another appointment for another time. They will soon know they can rely on you if they will make their appointment times with you.
- Be on time. Treat clients the way you want to be treated.
- Make a "grass-catcher" list. This is an ongoing list of things to be done, but do not have a specific deadline. When you are making your daily "to do" list, consult this "grass-catcher" list.
- Always ask "what is the best use of my time right now?"
- Do not always do other people's "A" tasks at the expense of your own.

Stress Management

- Talk with staff and your supervisor about your experiences and feelings. Sharing with others helps to reduce the tension and find humor in difficult situations.
- Learn how to use relaxation exercises.
- Use humor appropriately.
- Recognize the stages of burnout.

Stage I – Early Warning Signs

- Vague anxiety
- Constant fatigue
- Feelings of depression
- Boredom with one's job
- Apathy

Stage II – Initial Burnout

- Lowered emotional control
- Increasing anxiety
- Sleep disturbances
- Headaches
- Diffuse back and muscle aches
- Loss of energy
- Hyperactivity
- Excessive fatigue
- Moderate withdrawal from social contact

Stage III – Burnout

- Skin rashes
- Generalized physical weakness
- Strong feelings of depression
- Increased alcohol intake
- Increased smoking
- High blood pressure
- Ulcers
- Migraines
- Severe withdrawal
- Loss of appetite for food
- Loss of sexual appetite
- Excessive irritability
- Emotional outbursts
- Irrational fears (phobias)
- Rigid thinking

Stage IV – Burnout

- Asthma
- Coronary artery disease
- Diabetes
- Cancer
- Heart attacks
- Severe depression
- Lowered self-esteem
- Inability to function on job and personally

- Severe withdrawal
- Uncontrolled crying spells
- Suicidal thoughts
- Muscle tremors
- Severe fatigue
- Over-reaction to emotional stimuli
- Agitation
- Constant tension
- Accident proneness and carelessness
- Feelings of hostility

- Take action to deal with your burnout if you recognize it.
- Talk to your supervisor for assistance.
- Take time-outs. These can be mini time-outs, such as taking the afternoon off, or longer vacations.
- It is okay to say you are having a difficult time. We all do at times. It is not okay to ignore the stress symptoms and do nothing about them.
- Cultivate pleasurable activities and hobbies that will offer you balance and peace.
- Develop a positive, nurturing support system.
- Set limits for yourself and others. Know your own boundaries.
- Exercise regularly.

"Often the person who identifies himself as the curer or fixer-type healer is vulnerable to burnout." *(Rachel Naomi Remen, M.D.)*

"Perhaps the most important thing I have learned from my work is that I can be a friend and supporter of healing; I can be a guide to people; but it is not I who does the healing. I try to heal by creating situations that seem to allow or foster healing – calmness, faith, hope, enthusiasm – and sometimes just the idea that healing is a possibility." *(Martin Rossman, M.D.)*

VI. GLOSSARY

Acute phase of illness: A period of time during which the person suffers increased intensity of symptoms. It may last from a few days to several weeks.

ACOT Team: Assertive Community Outreach Treatment. A multidisciplinary team acting as the primary provider individualized treatment, rehabilitation, and support services to an identified population of high risk SMPI individuals to assist those persons live successfully in the community.

Adjustment disorder: A poorly suited response to life stress that usually disappears when the stress stops.

Adult Protective Services (APS): An entity responsible for the investigation of possible abuse, neglect, or exploitation of disabled adults and elderly.

Affect (flat): Absence of the common signs of normal emotions, such as smiling, laughing, etc.

Affect (inappropriate): Display of emotion that is out of place and does not relate to events.

Affect (labile): Abrupt, unpredictable shifts of emotion.

Akathisia: A common, unpleasant side effect of major tranquilizers that makes a person feel jittery and agitated.

Alogia: Poverty of thinking evidenced either by poverty of speech or by poverty of content of speech. (See also mutism)

Alzheimer's Disease: A common and irreversible form of dementia in which the brain atrophies. Death usually follows in six to ten years.

Ambivalence: The presence of strong opposing feelings that make it difficult for a person to reach a decision.

Anorexia nervosa: A common and serious eating disorder generally founding young women in which they gradually decrease the amount of food they eat until their weight becomes dangerously low.

Anti-anxiety medications: Medications used to help relieve tension and feelings of nervousness.

Anti-depressant medications: Medications used to treat serious depressions.

Anti-psychotic medications: Medications used to treat schizophrenia and other psychotic disorders.

Anti-social Personality Disorder: A diagnosis generally applied to individuals with long histories of continuous and chronic anti-social behavior, such as disregard for and violation of the rights of others.

Atypical psychosis: A diagnosis sometimes used when psychosis is observed but its causes are not understood.

Avoidant Personality Disorder: Characterized by hypersensitivity to rejection, and feelings of inadequacy and low self-esteem.

Avolition: Absence of initiative or motivation to begin and maintain behavior in pursuit of a goal.

Bipolar Disorder: A mood disorder in which a person experiences episodes of intense feelings of euphoria, and excitement, or irritability, followed by episodes of depression

Borderline Personality: A personality disorder characterized by instability of personal relationships, self-image, moods, and impulsivity.

Bulimia: Binge eating often accompanied by vomiting caused by concern over appearance and weight. This problem is related to anorexia nervosa and, in its severe form, can be life threatening.

Case manager: A employee of the CMHC, certified by the State Division of Substance Abuse and Mental Health.

Catatonic Schizophrenia: A type of schizophrenia characterized by pronounced motor symptoms ranging from rigid immobility to extreme excitement and excessive motor activity.

Chronic phase of illness: Refers to the persistence of illness or symptoms over a long period of time.

Civil Commitment (also called involuntary commitment): A judicial process whereby someone may be civilly committed against his/her will if the person is judged to be a substantial danger to others. *Please refer to S.B. 27, Susan Gall Involuntary Commitment Amendments:* http://www.le.state.ut.us/~2003/bills/sbillenr/sb0027.pdf

Club: May refer to client self-help clubs developed and organized by clients themselves, or psychosocial clubs that are program components of CMHCs. As the term implies, a club emphasizes belonging, social connections and common purposes.

CMHC: Community mental health center.

Confidentiality: A principle of medical practice that requires mental health treatment providers to keep confidential (not discuss) private treatment matters with other people without authorization from the client involved.

Day treatment (also called day hospital or partial hospitalization): A daily program of education activities therapy, crafts, recreation and social activities to help clients improved skills and feel better, generally after hospitalization. Day treatment programs are different in terms of their staff, operating hours, philosophy of treatment and methods.

DSPD: Division of Services for People with Disabilities.

Delusion: A false belief, which dominates a persons thinking despite evidence to the contrary.

Delusional Disorder: A disorder characterized by a system of nonbizarre delusions (i.e., involving situations that occur in real life, such as being followed, poisoned, infected, loved at a distance, or deceived by spouse or lover, or having a disease).

Dependant Personality Disorder: Characterized by an excessive need to be taken care of, and submissive and clinging behavior as well as feelings of panic or discomfort at having to be alone.

Depression: An emotional state characterized by extreme sadness, feelings of low self worth and thoughts of death and suicide.

Diagnosis: The assignment of a specific illness based on standardized symptoms assessed by a doctor, social worker, or other qualified personnel.

Disability Law Center (DLC): A private non-profit organization designated by the governor to protect the rights of people with disabilities in Utah. http://www.disabilitylawcenter.org/

Disorganized Type Schizophrenia: A type of Schizophrenia characterized by a prominence of disorganized speech, disorganized behavior, and inappropriate affect.

DSM-IV-TR: Diagnostic and Statistical Manual for Mental Disorders, Fourth Edition, Text Revision. Provides a definition of all recognized mental disorders.

Due process: A legal term meaning the right to an official court hearing before an individual's freedoms are restricted in any way, such as before involuntary hospitalization or treatment of any kind.

Food stamps: See Horizon Card.

GA: General Assistance

General Assistance: Public welfare, available to those who meet requirements.

Guardianship: A legal term describing the assignment of legal authority and responsibility from one person to another. This is done in a court of law and only in situations where the judge is convinced that the individual, whose guardianship is proposed, needs a guardian to protect his/her interest and rights.

Hallucinations: A perception in which things are seen or heard that are not real or present.

HEAT: Home Energy Assistance Target program. Federally funded program that helps qualified, low-income individuals pay the high cost of winter heating bills.

HHS: United States Department of Health and Human Services (http://www.os.dhhs.gov/).

Histrionic Personality Disorder: Characterized by excessive attention seeking behavior and emotional instability.

Horizon Card: Public welfare program administered by the Utah Department of Workforce Services.

HUD: Department of Housing and Urban Development (federal government).

Informed consent: The informed, conscious and willful agreement of an individual. A mental health professional cannot assume that a client has given informed consent unless the individual has been provided a full and complete explanation of the situation and his/her legal rights.

Inpatient: Refers to a treatment status of a person within a hospital or other medical facility.

Manic Depressive Illness: See bipolar disorder.

Medicaid: A health insurance program for low income people. It pays medical costs for eligible individuals who cannot afford the cost of health care. People who qualify for Supplemental Security Income (SSI) may be eligible for Medicaid.

Medicare: Insurance program of medical services for the elderly or those who have received SSDI for a period of time.

Medication, Psychiatric: Medicines prescribed by psychiatrists for the control of psychiatric symptoms.

Mental illness: A condition in which an individual's mental processes, including thoughts, feelings, and perceptions, are disrupted or dysfunctional in helping the person to adapt to his surroundings.

Mood Disorders: Disorders in which the primary feature is an intense disturbance in mood.

Mutism: Refusal or failure to speak when speech is expected or demanded.

NACM: National Association of Case Management (http://www.yournacm.com/)

NAMI: National Alliance for the Mentally Ill (http://www.nami.org/ or http://www.namiut.org/)

Narcissistic Personality Disorder: Characterized by grandiosity, need for admiration, and lack of empathy.

Needs assessment: A tool to obtain and represent the ongoing growth and changing needs of the client.

Negative symptoms: These symptoms involve the absence of normal behaviors. They include affective flattening, alogia, apathy, avolition and social withdrawal.

NIMH: National Institute of Mental Health (http://www.nimh.nih.gov/home.htm)

NMHA: National Mental Health Association (http://www.nmha.org/)

Obsessive-Compulsive Disorder (OCD): A pervasive pattern of preoccupation with orderliness, perfectionism, and mental and interpersonal control, at the expense of flexibility, openness, and efficiency.

Outpatient: Refers to a treatment status or a person receiving treatment in the community and outside of a mental hospital or other medical facility.

PAMI: Protection and Advocacy for the Mentally Ill (see Disability Law Center). Federal legislation which requires that will: 1) Ensure that the rights of individuals with mental illness are protected, 2) Pursue legal, administrative, and other remedies to ensure the protection of people with mental illness, and 3) Be independent of any agency in the state which provides treatment or services to mentally ill individuals.

Paranoid Type Schizophrenia: A type of schizophrenia characterized by a preoccupation with one or more delusions or frequent auditory hallucinations, which are often experienced as threatening to the person. Does not include prominent symptoms of disorganized speech, behavior or inappropriate affect.

Paranoid Personality Disorder: A pervasive distrust and suspiciousness of others.

PCN: See Primary Care Network

Personality Disorder: Refers to patterns of maladaption, inflexibility, or impairment in an individual's basic pattern of perceiving and relation to others.

Positive symptoms: These prominent or added symptoms include delusions, hallucinations, thought disorder, and aberrant behaviors.

Preferred Practice Guidelines: Uniform and consistent guidelines set by the State Division of Substance Abuse and Mental for housing and case management programs provided by the CMHC for people with mental illness. http://hsmh.utah.gov/pdf/Housing_In_Home_Skills_and_Case_Management_Preferred_Practice_Guidlines.pdf

Prevocational services: Activities intended to help a client prepare for employment by teaching work related skills.

Primary Care Network (PCN): A state health program to assist those individuals without health insurance, who do not qualify for Medicaid but do meet income guidelines.

Primary therapist: The person in a CMHC who has primary responsibility for providing and/or coordinating to ensure that clients receive the community services that they need.

Psychological screening: The use of psychological procedures or tests to detect psychological problems.

Psychopharmacological medications: Medications used in treatment of mental disorders.

Psychosis: A term that is used to describe major distortions or interpretations of reality. For example, the notion that one can control others or be controlled through brain waves transmitted via radio receivers.

Psychosocial rehabilitation (also called rehabilitation): A type of program oriented to helping clients reclaim or learn new skills that will help them manage better in the community. This type of program emphasizes employment goals and provides prevocational services as well as paid employment opportunities.

Psychosomatic: Perceived complaint pertaining to one's own body.

Psychotherapy: Treatment of mental disorders using psychological methods.

Rapport: Interpersonal relationship developed and characterized by a spirit of cooperation, confidence, and harmony.

Rationalization: Ego-defense mechanism created by an individual to justify his or her actions.

Remission of symptoms: The reduction or disappearance of symptoms of an illness.

Residual Type Schizophrenia: A type of schizophrenia that often follows the acute phase. Residual symptoms may include social isolation or withdrawal, major impairment in daily work roles, an apparent lack of feelings or expressiveness, or peculiar and strange ideas.

Resistive to treatment: From the point of view of a treatment provider, the characteristic of someone who directly or indirectly refuses treatment. In spite of this viewpoint, clients have the right to willfully choose or not choose treatments, except and unless that right is altered by a court of law.

Schizoaffective disorder: Mental disorder characterized by a person experiencing severe but highly episodic disturbances of psychological functioning, such as mood-incongruent delusions and hallucinations.

Schizoid personality disorder: Personality disorder characterized by shyness, seclusiveness, over sensitivity, and eccentricity.

Schizophrenia: A serious and sometimes disabling mental illness. Symptoms include so-called *positive symptoms,* such as hearing voices and developing false, unconfirmed ideas as well as *negative symptoms,* like withdrawing from friends and family.

Schizotypal Personality Disorder: A pervasive pattern of social and interpersonal deficits marked by acute discomfort with, and reduced capacity for close relationships and well as by cognitive or perceptual distortions and eccentricities of behavior.

Self-esteem: Overall feeling of self-worth.

Self-identity: An individual's delineation and awareness of his or her continuing identity as a person.

Self-monitoring: The observation and recording of one's own behavior.

Service Plan: A formal agreed upon plan for support and assistance provided to clients.

Side effects of medications: The common term for unintended effects of medication. These effects may include blurred vision, shakiness or twitching of muscles, or sleepiness.

Social Security Administration (SSA): The federal organization that administers SSDI, SSI and Medicare. These are all referred to as entitlement programs.

SSDI: Social Security Disability Insurance

SSI: Supplemental Security Income

Stress: Mental or physical tension or strain.

Substance Abuse Disorders: Pathological use of a substance resulting in self-injurious behavior.

Substance Use Disorder: Patterns of maladaptive behaviors centered around the regular and consistent use of the substance(s) involved.

Symptom: Particular evidence of illness, such as hallucinations, sleeplessness or other changes in personality.

Temporary Assistance for Needy Families (TANF): A federal block grant administered by states in ways to assist needy families.

Transient: Without a home or established place of residence.

UAMI: Utah Alliance for the Mentally Ill. This is the state organizational element of the National Alliance for the Mentally Ill (NAMI). (http://www.namiut.org/)

Undifferentiated Type Schizophrenia: A type of Schizophrenia in which the major symptoms are present but criteria for paranoid, disorganized, or catatonic types are not present.

Vocational Rehabilitation: A state government organization mandated to serve those who are unemployed by reason of some handicapping condition.

VRC: Vocational Rehabilitation Counselor

VII. SUGGESTED READINGS

Coping With Schizophrenia: A Guide for Families, by Kim Tornval Mueser and Susan Gingerich

Dealing with Drugs, Psychoactive Medications and Street Drugs and Their Good and Bad Effects on the Mentally Ill, by Jean K. Bouricius

Grieving Mental Illness: A Guide for Patients and their Caregivers, by Virginia Laford

Helping Someone with Mental Illness, by Rosalynn Carter

How to Get Control of Your Time and Your Life, by Allan Lakein

Is There No Place On Earth For Me? by Susan Sheehan

Overcoming Depression, by Dmitri F. Papolos and Janice Papolos

People Skills, by Robert Bolton

Schizophrenia Simplified: A Field Guide to Schizophrenia for Frontline Workers, Families, and Professionals, by J.F. Thornton, M.V. Seeman (Editor)

Surviving Schizophrenia: A Family Manual, by E. Fuller Torrey

VIII. APPENDICES

A. Psychiatric Medicines

ANTI-DEPRESSANTS

(Generic Name)	*(Trade Name)*
Amitriptyline	Elavil
Bupropion	Wellbutrin
Citalopram	Celexa
Clomipramine	Anafranil
Desipramine	Norpramine
Doxepin	Sinequan
Escitalopram	Lexapro
Fluoxetine	Prozac
Fluvoxamine	Luvox
Imipramine	Tofranil
Mirtazipine	Remeron
Nefazodone	Serzone
Nortriptyline	Pamelor
Paroxetine	Paxil
Pheneizine	Nardil
Sertraline	Zoloft
Tranylcypromine	Parnate
Trazodone	Desyrel
Venlafaxine	Effexor

ANTI-PSYCHOTICS

(Generic Name)	*(Trade Name)*
Apripiprazole	Abilify
Chlorpromazine	Thorazine
Clozapine	Clozaril
Fluphenazine	Prolixin
Haloperidol	Haldol
Loxapine	Loxitane
Mezoridazine	Serentil
Molindone	Moban
Olanzapine	Zyprexa
Perphenazine	Trilafon
Quetiapine	Seroquel
Risperidone	Risperdal
Thioridazine	Mellaril
Thiothixene	Navane
Thrifluoperazine	Stelazine
Ziprasidone	Geodon

ANTI-ANXIETY

(Generic Name)	*(Trade Name)*
Alprazolam	Xanax
Buspirone	BuSpar
Chlordiazepoxide	Librium
Clonazepam	Klonopin
Diazepam	Valium
Lorazepam	Ativan
Oxazepam	Serax
Temazepam	Restoril
Triazolam	Halcion
Zolpidem	Ambien

MEDS TO TREAT SIDE-EFFECTS
(ANTI-PARKINSON AGENTS)

(Generic Name)	*(Trade Name)*
Amantadine	Symmetrel
Benztropine	Cogentin
Diphenhydramine	Benadryl
Propranolol	Inderal
Trihexyphenidyl	Artane

MOOD STABILIZERS

(Generic Name)	*(Trade Name)*
Carbamazepine	Tegretol
Divalproex	Depakote
Gabapentin	Neurontin
Lamotrigine	Lamictal
Lithium	Eskalith
	Eskalith CR
	Lithobid
Oxcarbazepine	Trileptal
Valproic Acid	Depakene

OTHER

(Generic Name)	*(Trade Name)*
Chloral hydrate	Noctec
Clondine	Catapres
Disulfiram	Antabuse
Naltrexone	Revia

STIMULANTS

(Generic Name)	*(Trade Name)*
Caffeine	No Doz/Vivarin
Dextroamphetamine	Dexedrine
Methylphenidate	Ritalin
Pemoline	Cylert

ANTI-DEPRESSANTS:

Reason for taking: To treat depression. (When using: **Prozac, Paxil, Zoloft,** these medications also treat, obsessive-compulsive disorder (OCD), bulimia, premenstrual syndrome (PMS), posttraumatic stress disorder (PTSD), and social anxiety disorder.)

Side Effects: Restlessness, dizziness, dry mouth, headache, nausea, vomiting, constipation, agitation, weight gain, or hand tremors. These side effects may go away after awhile.

Precautions: Usually a few weeks are needed before conditions improve, keep on medication. Do not exceed recommended dose. Do not drink alcohol while taking medication.

ANTI-ANXIETY:

Reason for taking: To help relieve tension and feelings of nervousness.

Side Effects: Drowsiness, dizziness, extreme difficulty in coordinating movements, and severe diarrhea.

Precautions: Caution in driving or activities requiring alertness and/or coordination. Do not drink alcohol while taking medication.

ANTI-PSYCHOTICS:

Reason for taking: Decreases confusion, improves ones ability to understand what is real and imagined. Helps control unwanted voices, hallucinations, sounds, images, reduces anxiety and improves concentration and communication with other.

Side Effects: Dizziness, dry mouth, hand tremor, blurry vision, drowsiness, constipation, weight gain, muscle stiffness, restlessness, and increased sensitivity to sun. (**Clozaril**: rapid heartbeat, excessive salivation, as well as the other side effects.)

Precautions: Tell doctor if pregnant, do not mix with alcohol. (If using **Clozaril**, it can cause decreased white blood cells, which help fight off infection. Get weekly blood tests to determine if you should continue this medication.)

MOOD STABILIZERS:

Reason for taking: Generally prescribed as an anticonvulsant, but may be used to stabilize mood. (**Depakote**, also used to treat migraine headaches and manic episodes.) (**Lithium**, also used to treat manic-depression.)

Side Effects: That may go away during treatment, include blurred vision, dizziness, sleepy, unsteady, nausea or vomiting. (**Depakote**, indigestion, or hair loss.)

Precautions: Do not stop taking medication without consulting doctor. BEFORE ANY DENTAL OR MEDICAL TREATMENT, TELL PHYSICIAN WHAT MEDICATION YOU ARE TAKING. Do not drink alcohol while taking medication.

ANTI-PARKINSON AGENTS:

Reason for taking: To relieve side effects of anti-psychotics.

Side Effects: Dry mouth, blurred vision, dizziness, drowsiness, constipation, and difficulty urinating.

Precautions: Caution in driving or activities requiring alertness and/or coordination.

B. Utah Scale on the Seriously and Persistently Mentally Ill (SPMI) (for use with adults)

The following definition is used to identify individuals as seriously and persistently mentally ill.

DIMENSION I – SEVERITY: Mental health clients must meet three or more of the following criteria:

A. **MEDICATION:** Receives psychoactive medication as part of treatment.

B. **DIAGNOSIS/PROBLEM:** Diagnosis between 295 and 316, inclusively, or a problem of abuse victim syndrome.

C. **INAPPROPRIATE DEPENDENCY:** on other for any three of the following: (1) food purchase and preparation, (20) personal hygiene, (3) transportation, (4) financial management, (5) living arrangement, and (6) leisure management.

D. **PRODUCTIVITY PROBLEM:** Is either (1) marginally employed and would be unable to be employed without mental health services, (2) employed in a sheltered setting, (3) unemployable, or (4) receives specialized school or other services (if under age 16).

E. **SOCIAL ISOLATION:** Is socially isolated, without friends and social support systems. Uses mental health system for social exchange. Includes severe isolation in school (if under age 16).

F. **PUBLIC ASSISTANCE:** Receives public assistance to meet basic needs (Applies only to adult patients).

G. **SYMPTOM REMISSION:** Symptoms are in remission, but the patient's condition would seriously deteriorate without continued mental health treatment and support.

H. **ANTI-SOCIAL BEHAVIOR:** Has pattern of serious anti-social, criminal or delinquent acts.

DIMENSION II – PERSISTENCE: Must meet one of the following:

I. **MORE INTENSE TREATMENT:** History of a continuous episode of treatment more intensive than outpatient for two years or more.

J. **OUTPATIENT TREATMENT:** History of a continuous episode of treatment in outpatient services for three years or more.

K. **NO HISTORY:** Would meet above criterion I or J if service history were available or has met the severity criteria for three years or more without service.

L. **RESISTIVE TO TREATMENT:** Is resistive to treatment and would meet criterion I or J had the patient not terminated for service against advice. Includes mental health-focused schooling (if under age 16).

M. **PROSPECTIVE PERSISTENCE:** Extremely like to meet criterion I or J by subsequent continuous service or is expected to meet the severity criteria for three years or more

C. Utah State Abuse and Neglect Reporting Laws

76-5-111.1. Reporting requirements.

(1) Any person, including but not limited to, a social worker, physician, psychologist, nurse, teacher, or employee of a private or public facility serving adults, who has reason to believe that any disabled or elder adult has been the subject of abuse, emotional or psychological abuse, neglect, or exploitation shall immediately notify the nearest peace officer, law enforcement agency, or local office of Adult Protective Services within the Department of Human Services, Division of Aging and Adult Services.

(2) Anyone who makes that report in good faith is immune from civil liability in connection with the report.

(3) (a) When the initial report is made to a peace officer or law enforcement agency, and the disabled or elder adult requires protection, the officer or agency shall immediately notify the nearest local office of Adult Protective Services and that office shall coordinate its investigation with law enforcement, and provide protection to the disabled or elder adult as necessary.

(b) When the initial report involves a resident of a long-term care facility, as defined in Section **62A-3-202**, the local long-term care ombudsman within the Department of Human Services, Division of Aging and Adult Services, shall be immediately notified. The ombudsman and the local Adult Protective Services office shall cooperate in conducting the investigation.

(c) When the initial report or investigation by an Adult Protective Services office indicates that criminal abuse, neglect, or exploitation, as defined in Section **76-5-111** has occurred, or that any other criminal offense against a disabled or elder adult has occurred, the local Adult Protective Services office shall immediately notify the local law enforcement agency. That law enforcement agency shall initiate an investigation in cooperation with the local Adult Protective Services office.

(4) A person who is required to report suspected abuse, emotional or psychological abuse, neglect, or exploitation of a disabled or elder adult under Subsection (1), and who willfully fails to do so, is guilty of a class B misdemeanor.

62A-3-305. Reporting requirements -- Investigation -- Immunity -- Violation -- Penalty -- Physician-patient privilege -- Nonmedical healing.

(1) Any person who has reason to believe that any vulnerable adult has been the subject of abuse, neglect, or exploitation shall immediately notify Adult Protective Services intake or the nearest law enforcement agency. When the initial report is made to law enforcement, law enforcement shall immediately notify Adult Protective Services intake. Adult Protective Services and law enforcement shall coordinate, as appropriate, their efforts to provide protection to the vulnerable adult.

(2) When the initial report or subsequent investigation by Adult Protective Services indicates that a criminal offense may have occurred against a vulnerable adult, it shall notify the nearest local law enforcement agency. That law enforcement agency shall initiate an investigation in cooperation with Adult Protective Services.

(3) Anyone who in good faith makes a report or otherwise notifies a law enforcement agency, the division, or Adult Protective Services of suspected abuse, neglect, or exploitation is immune from civil and criminal liability in connection with the report or other notification.

(4) Any person who willfully fails to report suspected abuse, neglect, or exploitation of a

vulnerable adult is guilty of a class B misdemeanor.

(5) Under circumstances not amounting to a violation of Section **76-8-508**, a person who threatens, intimidates, or attempts to intimidate a vulnerable adult who is the subject of a report, a witness, the person who made the report, or any other person cooperating with an investigation conducted pursuant to this chapter is guilty of a class B misdemeanor.

(6) The physician-patient privilege does not constitute grounds for excluding evidence regarding a vulnerable adult's injuries, or the cause of those injuries, in any judicial or administrative proceeding resulting from a report made in good faith pursuant to this part.

(7) An adult is not considered abused, neglected, or a vulnerable adult for the reason that the adult has chosen to rely solely upon religious, nonmedical forms of healing in lieu of medical care.

D. Provider Code of Conduct

DEPARTMENT OF HUMAN SERVICES POLICY & PROCEDURES		
Department of Human Services		
Reference: 05-03	**Effective Date: May 23, 1989**	**Revision Date: August 17, 2001**
PROVIDER CODE OF CONDUCT		
RATIONALE: The purpose of this Provider Code of Conduct is to protect the clients of the Department of Human Services, to establish a consistent standard of conduct for the Providers who serve those clients, and to promote conduct that reflects respect for clients and others. (This policy incorporates the provisions of Rule 495-876.)		

I. STATEMENT OF PURPOSE.

The Department of Human Services ("DHS") adopts this Code of Conduct to:

(a) Protect its clients from abuse, neglect, maltreatment and exploitation; and

(b) Clarify the expectation of conduct for DHS Providers and their employees and volunteers who interact in any way with DHS clients, DHS staff and the public.

The Provider shall distribute a copy of this Code of Conduct to each employee and volunteer, regardless of whether the employees or volunteers provide direct care to clients, indirect care, administrative services or support services. The Provider shall require each employee and volunteer to read the Code of Conduct and sign a copy of the attached "Certificate of Understanding" before having any contact with DHS clients. The Provider shall file a copy of the signed Certificate of Understanding in each employee and volunteer's personnel file. The Provider shall also maintain a written policy that adequately addresses the appropriate treatment of clients and that prohibits the abuse, neglect, maltreatment or exploitation of clients. This policy shall also require the Provider's employees and volunteers to deal with DHS staff and the public with courtesy and professionalism.

This Code of Conduct supplements various statutes, policies and rules that govern the delivery of services to DHS clients. The Providers and the DHS Divisions or Offices may not adopt or enforce policies that are less stringent than this Code of Conduct unless those policies have first been approved in writing by the Office of Licensing and the Executive Director of the Utah Department of Human Services. Nothing in this Code of Conduct shall be interpreted to mean that clients are not accountable for their own misbehavior or inappropriate behavior, or that Providers are restricted from imposing appropriate sanctions for such behavior

II. DEFINITIONS.

1. General Definitions:

"Client" means anyone who receives services either from DHS or from a Provider pursuant to an agreement with DHS or funding from DHS.

"DHS" means the Utah Department of Human Services or any of its divisions, offices or agencies.

"Domestic-violence-related child abuse" means any domestic violence or a violent physical or verbal interaction between cohabitants in the physical presence of a child or having knowledge that a child is present and may see or hear an act of domestic violence.

"Emotional maltreatment" means conduct that subjects the client to psychologically destructive behavior, and includes conduct such as making demeaning comments, threatening harm, terrorizing the client or engaging in a systematic process of alienating the client.

"Provider" means any individual or business entity that contracts with DHS or with a DHS contractor to provide services to DHS clients. The term "Provider" also includes licensed or certified individuals who provide services to DHS clients under the supervision or direction of a Provider. Where this Code of Conduct states (as in Sections III-VII) that the "Provider" shall comply with certain requirements and not engage in various forms of abuse, neglect, exploitation or maltreatment, the term "Provider" also refers to the Provider's employees, volunteers and subcontractors, and others who act on the Provider's behalf or under the Provider's control or supervision.

"Restraint" means the use of physical force or a mechanical device to restrict an individual's freedom of movement or an individual's normal access to his or her body. "Restraint" also includes the use of a drug that is not standard treatment for the individual and that is used to control the individual's behavior or to restrict the individual's freedom of movement.

"Seclusion" means the involuntary confinement of the individual in a room or an area where the individual is physically prevented from leaving.

"Written agency policy" means written policy established by the Provider. If a written agency policy contains provisions that are more lenient than the provisions of this Code of Conduct, those provisions must be approved in writing by the DHS Executive Director and the Office of Licensing.

B. Definitions of Prohibited Abuse, Neglect, Maltreatment and Exploitation:

"Abuse" includes but is not limited to:

1. Harm or threatened harm to the physical or emotional health and welfare of a client.

2. Unlawful confinement.

3. Deprivation of life-sustaining treatment except in accordance with a valid advance directive or other legally-sufficient written directive from a competent client or the client's legal representative (e.g., a parent or legal guardian).

4. Physical injury, such as a contusion of the skin, laceration, malnutrition, burn, fracture of any bone, subdural hematoma, injury to any internal organ, any injury causing bleeding, or any physical condition which imperils a client's health or welfare.

5. Any type of unlawful hitting or corporal punishment.

6. Domestic-violence-related child abuse.

7. Any sexual abuse or sexual exploitation, including but not limited to:

    a. Engaging in sexual intercourse with any client.

    b. Touching the anus or any part of the genitals or otherwise taking indecent liberties with a client, or causing an individual to take indecent liberties with a client, with the intent to arouse or gratify the sexual desire of any person.

    c. Employing, using, persuading, inducing, enticing, or coercing a client to pose in the nude.

    d. Engaging a client as an observer or participant in sexual acts.

    e. Employing, using, persuading, inducing, enticing or coercing a client to engage in any sexual or simulated sexual conduct for the purpose of photographing, filming, recording, or displaying in any way the sexual or simulated sexual conduct. This includes displaying, distributing, possessing for the purpose of distribution, or selling material depicting nudity, or engaging in sexual or simulated sexual conduct with a client.

    f. Committing or attempting to commit acts of sodomy or molestation with a client.

    As used in this Code of Conduct, the terms Asexual abuse, and Asexual exploitation, do not refer to approved therapeutic processes used in the treatment of sexual deviancy or dysfunction as long as those therapeutic processes have been outlined in the client's treatment plan and are consistent with generally-accepted therapeutic practices and written agency policy.

"Neglect" includes but is not limited to:

1. Denial of sufficient nutrition.

2. Denial of sufficient sleep.

3. Denial of sufficient clothing, or bedding.

4. Failure to provide adequate client supervision, including situations where the Provider's employee or volunteer is asleep or ill on the job, or is impaired due to the use of alcohol or drugs.

5. Failure to provide care and treatment as prescribed by the client's service, program or treatment plan, including failure to arrange for medical or dental care or treatment as prescribed or as instructed by the client's physician or dentist, unless the client or the Provider obtains a second opinion from another physician or dentist, indicating that the originally-prescribed medical or dental care or treatment is unnecessary.

6. Denial of sufficient shelter, where shelter is part of the services the Provider is responsible for providing to the client.

7. Educational neglect (i.e., willful failure or refusal to make a good faith effort to ensure that a child in the Provider's care or custody receives an appropriate education).

"Exploitation" includes but is not limited to:

1. Using a client's property without the client's consent or using a client's property in a way that is contrary to the client's best interests, such as expending a client's funds for the benefit of another.

2. Making unjust or improper use of clients or their resources.

3. Accepting a gift in exchange for preferential treatment of a client or in exchange for services that the Provider is already obliged to provide to the client.

4. Using the labor of a client for personal gain.

5. Using the labor of a client without paying the client a fair wage or without providing the client with just or equivalent non-monetary compensation, except where such use is consistent with standard therapeutic practices and is authorized by DHS policy or the Provider's contract with DHS.

    a. Examples:

    (i) It is not "exploitation" for a foster parent to assign an extra chore to a foster child who has broken a household rule, because the extra chore is reasonable discipline and teaches the child to obey the household rules.

(ii) It is not "exploitation" to require clients to help serve a meal at a senior center where they receive free meals and are encouraged to socialize with other clients. The meal is a non-monetary compensation, and the interaction with other clients may serve the clients' therapeutic needs.

(iii) It is usually "exploitation" to require a client to provide extensive janitorial or household services without pay, unless the services are actually an integral part of the therapeutic program, such as in "clubhouse" type programs that have been approved by DHS.

"Maltreatment" includes but is not limited to:

1. Physical exercises, such as running laps or performing pushups, except where such exercises are consistent with an individual's service plan and written agency policy and with the individual's health and abilities.

2. Any form of Restraint or Seclusion used by the Provider for reasons of convenience or to coerce, discipline or retaliate against a client. The Provider may use a Restraint or Seclusion only in emergency situations where such use is necessary to ensure the safety of the client or others and where less restrictive interventions would be ineffective, and only if the use is authorized by the client's service plan and administered by trained authorized personnel. Any use of Restraint or Seclusion must end immediately once the emergency safety situation is resolved. The Provider shall comply with all applicable laws about Restraints or Seclusion, including all federal and state statutes, regulations, rules and policies.

3. Assignment of unduly physically strenuous or harsh work or exercise.

4. Requiring or forcing the client to take an uncomfortable position, such as squatting or bending, or requiring or forcing the client to repeat physical movements as a means of punishment.

5. Group punishments for misbehavior of individuals.

6. Emotional maltreatment, bullying, teasing, provoking or otherwise verbally or physically intimidating or agitating a client.

7. Denial of any essential program service solely for disciplinary purposes.

8. Denial of visiting or communication privileges with family or significant others solely for disciplinary purposes.

9. Requiring the individual to remain silent for long periods of time for the purpose of punishment.

10. Extensive withholding of emotional response or stimulation.

11. Denying a current client from entering the client's residence, where such denial is for disciplinary or retaliatory purposes or for any purpose unrelated to the safety of clients or others.

III. ABUSE, NEGLECT, EXPLOITATION AND MALTREATMENT ARE PROHIBITED.

Providers shall not abuse, neglect, exploit or maltreat clients in any way, whether through acts or omissions or by encouraging others to act or by failing to deter others from acting.

IV. PROVIDER'S COMPLIANCE WITH CONDUCT REQUIREMENTS IMPOSED BY LAW, CONTRACT OR OTHER POLICIES.

In addition to complying with this Code of Conduct, the Provider shall comply with all applicable laws (such as statutes, rules and court decisions) and all policies adopted by the DHS Office of Licensing, by the DHS Divisions or Offices whose clients the Provider serves, and by other state and federal agencies that regulate or oversee the Provider's programs. Where the Office of Licensing or another DHS entity has adopted a policy that is more specific or restrictive than this Code of Conduct, that policy shall control. If a statute, rule or policy defines abuse, neglect, exploitation or maltreatment as including conduct that is not expressly included in this Code of Conduct, such conduct shall also constitute a violation of this Code of Conduct. *See, e.g.,* Title 62A, Chapter 3 of the Utah Code (definition of adult abuse) and Title 78, Chapter 3a and Title 76, Chapter 5 of the Utah Code (definitions of child abuse).

V. THE PROVIDER'S INTERACTIONS WITH DHS PERSONNEL AND THE PUBLIC.

In carrying out all DHS-related business, the Provider shall conduct itself with professionalism and shall treat DHS personnel, the members of the Provider's staff and members of the public courteously and fairly. The Provider shall not engage in criminal conduct or in any fraud or other financial misconduct.

VI. SANCTIONS FOR NON-COMPLIANCE.

If a Provider or its employee or volunteer fail to comply with this Code of Conduct, DHS may impose appropriate sanctions (such as corrective action, probation, suspension, disbarment from State contracts, and termination of the Provider's license or certification) and may avail itself of all legal and equitable remedies (such as money damages and termination of the Provider's contract). In imposing such sanctions and remedies, DHS shall comply with the Utah Administrative Procedures Act and applicable DHS rules. In appropriate circumstances, DHS shall also report the Provider's misconduct to law enforcement and to the Provider's clients and their families or legal representatives (e.g., a legal guardian). In all cases, DHS shall also report the Provider's misconduct to the licensing authorities, including the DHS Office of Licensing.

VII. PROVIDERS' DUTY TO HELP DHS PROTECT CLIENTS.

1. **Duty to Protect Clients' Health and Safety.** If the Provider becomes aware that a client has been subjected to any abuse, neglect, exploitation or maltreatment, the Provider's first duty is to protect the client's health and safety.

2. **Duty to Report Problems and Cooperate with Investigations.** Providers shall document and report any abuse, neglect, exploitation or maltreatment and exploitation as outlined in this Code of Conduct, and they shall cooperate fully in any investigation conducted by DHS, law enforcement or other regulatory or monitoring agencies.

    a. Except as provided in Section (B)(1)(a) and (B)(3) below, Providers shall immediately report abuse, neglect, exploitation or maltreatment by contacting the local Regional Office of the appropriate DHS Division or Office. During weekends and on holidays, Providers shall make such reports to the on-call worker of that Regional Office.

        (i) Providers shall report any abuse or neglect of disabled or elder adults to the Adult Protective Services intake office of the Division of Aging and Adult Services.

    b. The Provider shall make all reports and documentation about abuse, neglect, exploitation, and maltreatment available to appropriate DHS personnel and law enforcement upon request.

    c. Providers shall document any client injury (explained or unexplained) that occurs on the Providers' premises or while the client is under the Provider's care and supervision, and the Provider shall report any such injury to supervisory personnel immediately. Providers shall cooperate fully in any investigation conducted by DHS, law enforcement or other regulatory or monitoring agencies. If the client's injury is minimal, the Provider has 12 hours to report the injury. The term "extremely minimal" refers to injuries that obviously do not require medical attention (beyond washing a minor wound and applying a band-aid, for example) and which cannot reasonably be expected to benefit from advice or consultation from the supervisory personnel or medical practitioners.

        (i) Example: If a foster child falls off a swing and skins her knee slightly, the foster parent shall document the injury and report to the foster care worker within 12 hours.

        (ii) Example: If a foster child falls off a swing and sprains or twists her ankle, the foster parent shall document the injury and report it immediately to supervisory personnel because the supervisor may want the child's ankle X-rayed or examined by a physician.

3. **Duty to Report Fatalities and Cooperate in Investigations and Fatality Reviews.** If a DHS client dies while receiving services from the Provider, the Provider shall notify the supervising DHS Division or Office immediately and shall cooperate with any investigation into the client's death. In addition, some Providers are subject to the Department of Human Services' Fatality Review Policy. (See the "Eligibility" section of DHS Policy No. 05-02 for a description of the entities subject to the fatal-review requirements. A copy of the policy is available at the DHS web site at: http://www.dhs.state.ut.us/policy.htm.) If the Provider is subject to the Fatality Review Policy, it shall comply with that policy (including all reporting requirements) and the Provider shall cooperate fully with any fatality reviews and investigations concerning a client death.

4. **Duty to Display DHS Poster.** The Provider shall prominently display in each facility a DHS poster that notifies employees of their responsibilities to report violations of this Provider Code of Conduct, and that gives phone numbers for the Regional Office or Intake Office of the relevant DHS Division(s). Notwithstanding the foregoing, if the Provider provides its services in a private home and if the Provider has fewer than three employees or volunteers, the Provider shall maintain this information in a readily-accessible place but it need not actually display the DHS poster. DHS shall annually provide the Provider with a copy of the current DHS poster or it shall make the poster available on the DHS web site: http://www.dhs.state.ut.us/.

DATE: 08-17-01

Robin Arnold-Williams, Executive Director
Department of Human Services

PROVIDER CODE OF CONDUCT
CERTIFICATE OF UNDERSTANDING AND COMPLIANCE

(To be signed by all DHS Providers and their employees, volunteers and subcontractors.)

I have read and been provided with a personal copy of the Provider Code of Conduct for the Utah Department of Human Services.

I understand this Code of Conduct and I will comply with it. I have had an opportunity to ask questions and seek clarification about the Code of Conduct, and my questions have been answered to my satisfaction and understanding.

_____

Signature of Employee or Volunteer Date

Print Name: _____

_____

Signature of Supervisor Date

Print Name: _____

_____

Program/Facility

_____

Street Address

_____

City, State, ZIP Code

The Provider shall place a copy of this signed "Certificate of Understanding and Compliance" in the signer's personnel file and shall make that file available to DHS upon request.

E. Directory of Utah Community Support Services

This directory contains the names, addresses, and phone numbers of community support services in Utah. It does not include all agencies, or all services that might be needed or used by clients. It does include some of the most important ones. For example, CMHCs and client advocacy groups that can assist clients and their families in locating specialized forms of help.

Service categories are listed in the contents. Within each category, services are listed alphabetically by CMHC.

ADULT DAY TREATMENT/SKILLS DEVELOPMENT SERVICES (SDS) AND/OR CLUBHOUSE PROGRAMS

Bear River Mental Health

Bear River House
88 W. 1000 N.
Logan, UT 84321
(435) 753-2080

Central Utah Counseling

Central Utah Counseling - Clubhouse
390 West 100 North
Ephraim, UT 84627
(435) 283-4065

Central Utah Counseling - Clubhouse
51 N. Main
Delta, UT 84624
(435) 864-3073

Central Utah Counseling - Clubhouse
255 S. Main
Richfield, UT 84701
(435) 896-8236

Davis Behavioral Health

Davis Place
836 S. State
Clearfield, UT 84015
(801) 774-6580

Davis Place Work Center
904 S. State
Clearfield, UT 84015
(801) 776-8600

Four Corners Community Behavioral Health

New Heights Clubhouse
77 South 600 East
Price, UT 84501
(435) 637-4246

Interact Clubhouse
59 N. 200 E.
Moab, UT 84532
(435) 259-7340

Northeastern Counseling Center

Vernal Friends House
360 North 900 West
Vernal, UT 84078
(435) 781-1409

Roosevelt Rendezvous
178 West 100 South
Roosevelt, UT 84066
(435) 722-4958

San Juan Counseling Center

Blanding Day Treatment
171 N. 200 W.
Blanding, UT 84511
(435) 678-3000

Montezuma Creek Day Treatment
UNDC #22
Montezuma Creek, UT 84535
(435) 651-3294

Southwest Center

Oasis House
2111 North Main, Suite 6
Cedar City, UT 84720
(435) 586-0213

Independence House
960 North Dixie Downs Rd.
St. George, UT 84770
(435) 628-0612

Valley Mental Health – Salt Lake

Valley Mental Health
Adult Day Treatment (ADT)
1020 South Main
Salt Lake City, UT 84101
(801) 536-6500

Valley Mental Health
Alcohol and Drug
5965 South 900 East
Salt Lake City, UT 84121
(801) 263-7225

Valley Mental Health
Alliance House
1724 South Main
Salt Lake City, UT 84115
(801) 486-5012

Valley Mental Health
Forensics
530 East 500 South
Salt Lake City, UT 84102
(801) 538-2057

Valley Mental Health
Storefront
550 West 700 South
Salt Lake City, UT 84101
(801) 537-7537

Valley Mental Health
Master's Program
4460 South Highland Drive
Salt Lake City, UT 84124
(801) 273-1085

Valley Mental Health – Summit

Valley Mental Health
1753 Sidewinder #S200
Park City, UT 84060
(435) 649-9079

Valley Mental Health – Tooele

Valley Mental Health
100 South 1000 West
Tooele, UT 84074
(435) 843-3520

Valley Mental Health
New Reflections House
565 West 900 South
Tooele, UT 84074
(435) 882-4845

Wasatch Mental Health

Lakeview Day Treatment 175 East 300 North Provo, Utah 84606
(801) 373-7443

Weber Human Services

SDS Center
238 27th St.
Ogden, UT 84401
(801) 625-3628

ADVOCACY ORGANIZATIONS/ CONSUMER ADVOCACY GROUPS

Bear River Mental Health

Box Elder- NAMI Utah
Brigham City, Utah
Sara & John Hoffman
(435) 723-1866

NAMI Utah - Cache Valley Affiliate
Providence, UT 84332
Wendy Simmons
Dell Allen
(435) 753-0851
(435) 755-8720

Central Utah Counseling

Delta- NAMI Utah
Delta, Utah 84624
Linda Lundberg
(435) 864-5583

Davis Behavioral Health

Davis AMI
Bountiful, UT 84010
Teri Stock
(801) 299-0384

Four Corners Community Behavioral Health

Four Corners – AMI
Moab, UT 84532
Ann LaMunyon
(435) 259-8600

Castle County AMI
Price, UT 84501
Lynette Tucker
(435) 653-2739

Green River - NAMI Utah
Green River, UT 84525
Joni Pace
(435) 564-3593

Northeastern Counseling Center

NAMI Utah
309 East 100 South
Salt Lake City, UT 84111
(801) 323-9900
1-877-230-6264

San Juan Counseling Center

NAMI Utah
309 East 100 South
Salt Lake City, UT 84111
(801) 323-9900
1-877-230-6264

Southwest Center

Cedar City – NAMI Utah
Cedar City, Utah 84720
Rosie Fletcher
(435) 586-0536

Southwest- AMI
St. George, UT 84745
DeAnn Cox

(435) 628-3658

Oasis House
2111 N Main Suite 6
Cedar City, UT 84720
(435) 586-0213

Independence House
960 N. Dixie Downs Rd.
St. George, UT 84770
(435) 628-0612

Valley Mental Health – Salt Lake

NAMI
Utah Alliance for the Mentally Ill
309 East 100 South
Salt Lake City, UT 84111
(801) 323-9900

Community Action Program
764 South 200 West
Salt Lake City, UT 84101
(801) 359-2444

Disability Law Center
455 East 450 South, Suite 410
Salt Lake City, UT 84111
(801) 363-1347

J.E.D.I. Woman (Justice, Economic Dignity & Independence)
352 South Denver
Salt Lake City, UT 84111
(801) 364-8562

Mental Health Association of Utah
1800 South West Temple
Salt Lake City, UT 84115
(801) 596-3705

Utahns Against Hunger
309 East 100 South
Salt Lake City, UT 84111
(801) 328-2561

Utah Issues
331 South Rio Grande
Salt Lake City, UT 84101
(801) 521-2035

Valley Mental Health
5965 South 900 East
Salt Lake City, UT 84121
(801) 263-7100

Information and Referral
Phone: 211
http://www.informationandreferral.org/

Valley Mental Health – Summit

Valley Mental Health
1753 Sidewinder #S200
Park City, UT 84060
(435) 649-9079

NAMI
Utah Alliance for the Mentally Ill
Park City, UT
(435) 645-7896

Valley Mental Health – Tooele

Valley Mental Health
100 South 1000 West
Tooele, UT 84074
(435) 843-3520

New Reflections House
565 West 900 South
Tooele, UT 84074
(435) 882-4845

Wasatch Mental Health

NAMI
Utah Alliance for the Mentally Ill
Utah County Affiliate
Contacts:
Grover Jensen (801) 225-6890

Bruce and Ruth Smith (801) 225-6890

Weber Human Services

NAMI Utah
Weber Affiliate Presidents
Steve and Suzanne Brown
(801) 732-8800

PAAG, Inc
2568 Washington Blvd Suite 101
Ogden, UT 84401
(801) 621-2215

COMMUNITY MENTAL HEALTH CENTERS AND OUTPATIENT CLINICS

Bear River Mental Health

Bear River Mental Health
90 East 200 North
Logan, UT 84321
(435) 752-0750

Bear River Mental Health
663 West Hospital
Brigham City, UT 84302
(435) 734-9449

Bear River House
88 West 1000 North
Logan, UT 84321
(435) 753-2080

24-Hour Housing
1115 North Main Street
Logan, UT 84321
(435) 753-7053

Central Utah Counseling

Central Utah Counseling &
Substance Abuse Center
255 West Main
Mt. Pleasant, UT 84647
(435) 462-2416
1-800-523-7412

Richfield Office
255 S. Main
Richfield, UT 84701
(435) 896-8236
1-800-746-9070

Millard County/Delta Office
PO Box 357
Delta, UT 84624
(435) 864-3073
1-800-343-3073

Fillmore Office
71 West Center
Fillmore, UT 84631
(435) 743-5121

Ephraim Office
390 West 100 North
Ephraim, UT 84627
(435) 283-4065
1-800-283-4045

Residential Unit
125 South State
Mt. Pleasant, UT 84647
(435) 462-2421

Nephi Office
656 North Main
Nephi, UT 84648
(435) 623-1456

Davis Behavioral Health

Davis Behavioral Health
291 South 200 West
Farmington, UT 84025
(801) 451-7799

Extended Care Services
904 S. State Street
Clearfield, UT 84015
(801) 776-8600 or 776-3147

Davis Place
836 South State
Clearfield, UT 84015
(801) 774-6580

Layton Out-Patient
2250 N. 1700 W.
Layton, UT 84041
(801) 773-7060

Outreach Office
470 Medical Drive
Bountiful, UT 84010
(801) 298-3446

Four Corners Community Behavioral Health

Four Corners Community
Behavioral Health, Inc.:
Administrative Plaza
PO Box 867
105 W. 100 N. #2
Price, UT 84501
(435) 637-7200

Price Office
PO Box 867 575 E 100 So
Price, UT 84501
(435) 637-2358

Carbon/Emery Community
Outreach Treatment Team
77 So 600 East
Price, UT 84501
(435) 637-2358

Castle Dale Office
PO Box 387
Castle Dale, UT 84513
(435) 381-2432

Moab Office
198 East Center
Moab, UT 84532
(435) 259-6131

Northeastern Counseling Center

Main Office
1140 W. 500 S.
P.O. Box 1908
Vernal, UT 84078
(435) 789-6300

Roosevelt Office
285 West 800 South
Roosevelt, UT 84066
(435) 725-6300

Duchesne Office
54 East 200 South
Duchesne, Utah 84021
(435) 738-5512

Daggett County Office
95 North 100 West
Manila, UT 84046
(435) 784-3006

San Juan Counseling Center

San Juan Counseling Center
356 South Main
Blanding, UT 84511
435) 678-2992

San Juan Counseling
Monticello Office
Monticello, UT 84535
(435) 678-2992

San Juan Counseling
Montezuma Creek Clinic
Montezuma, UT 84534
(435) 651-3294

Southwest Center

Washington County
474 W. 200 N.
St. George, UT 84770
(435) 634-5600

Southwest Center Outpatient
Beaver County
757 N. Main
P.O. Box 1485
Beaver, UT 84713
(435) 438-5537
Emergency (435) 438-2862

Southwest Center Outpatient
Iron County
245 E. 680 S.
Cedar City, UT 84720
(435) 867-7654

Southwest Center Outpatient
Garfield County
609 N. Main #4
P.O. Box 579
Panguitch, UT 84759
(435) 676-8176
Emergency (435) 676-2411

Southwest Center Outpatient
Kane County
310 S. 100 E. Suite 11
Kanab, UT 84741
(435) 644-4520
Emergency (435) 644-2349

Valley Mental Health – Salt Lake

Valley Mental Health
5965 South 900 East
Salt Lake City, UT 84121
(801) 263-7100

Valley Mental Health
North Valley
1020 South Main
Salt Lake City, UT 84101
(801) 539-7000

Valley Mental Health
South Valley
7434 South State
Midvale, UT 84047
(801) 566-4423

Valley Mental Health
Storefront
550 West 700 South
Salt Lake City, UT 84101
(801) 537-7537

Valley Mental Health
Alcohol and Drug
5965 South 900 East
Salt Lake City, UT 84121
(801) 263-7225

Valley Mental Health
Forensics
530 East 500 South
Salt Lake City, UT 84102
(801) 538-2057

Valley Mental Health
Master's Program
4460 South Highland Drive
Salt Lake City, UT 84124
(801) 273-1085

Valley Mental Health – Summit

Valley Mental Health
1753 Sidewinder #S200
Park City, UT 84060
(435) 649-9079

Valley Mental Health – Tooele

Valley Mental Health
100 South 1000 West
Tooele, UT 84074
(435) 843-3520

Wasatch Mental Health

Wasatch Mental Health
750 North 200 West
Provo, Utah 84601
(801) 373-4760

Weber Human Services

Weber Human Services
237 26th St.
Ogden, UT 84401
(801) 625-3700

EMPLOYMENT SERVICES

Bear River Mental Health

Bear River House
Employment Program
88 W. 1000 N.
Logan, UT 84321
(435) 753-2080

Northeastern Counseling Center

Vernal Employment Center
1050 West Market Dr.
Vernal, UT 84078
(435) 781-4100

Southwest Center

Oasis House
2111 N Main Suite 6
Cedar City, UT 84720
(435) 586-0213

Independence House
960 N. Dixie Downs Rd.
St. George, UT 84770
(435) 628-0612

Valley Mental Health – Salt Lake

Valley Mental Health
Alliance House
1724 South Main
Salt Lake City, UT 84115
(801) 486-5012

Valley Services
3685 West 6200 South
Kearns, Utah 84118
(801) 965-8142

Valley Mental Health – Summit

Information and Referral
Phone: 211
http://www.informationandreferral.org/

Valley Mental Health – Tooele

Valley Mental Health
100 South 1000 West
Tooele, UT 84074
(435) 843-3520

Wasatch Mental Health

Department of Workforce Services
1550 N. Freedom Boulevard

Provo, UT
(801) 374-7740

Wasatch Mental Health
Wasatch House (Clubhouse program)
605 East 600 South
Provo, UT 84606
(801) 373-7440

Weber Human Services

Supported Employment Training Program (STEP House)
685 25th
Ogden, UT 84401
(801) 399-8705

FAMILY CENTERS

Bear River Mental Health

Cache Valley Family Center
50 South 400 East
Logan, UT 84341
(435) 755-5171

Davis Behavioral Health

Davis Family Enrichment Center
320 South 500 East
Kaysville, UT 84037
(801) 402-7309 ext 116

Four Corners Community Behavioral Health

Monument Valley Family Center
PO Box 360008
Monument Valley, UT 84536
(435) 727-3204

Southwest Center

Family Support Center of Washington County
513 North 500 West
St. George, UT 84770
(435) 674-4111

Valley Mental Health – Salt Lake

Salt Lake Family Center – Horizonte
1234 South Main #321
Salt Lake City, Utah 84101
(801) 578-8490

Statewide Utah Family Center
5192 South Greenpine Dr.
Salt Lake City, Utah 84123
(801) 373-info

Valley Mental Health – Summit

Information and Referral
Phone: 211
http://www.informationandreferral.org/

Valley Mental Health – Tooele

Information and Referral
Phone: 211
http://www.informationandreferral.org/

Wasatch Mental Health

Utah County Family Center
150 South 500 East
Provo, UT 84606
(801) 367-8029

Weber Human Services

Weber Human Services
237 26th St.
Ogden, UT 84401
(801) 625-3700

HOMELESS SERVICES

Four Corners Community Behavioral Health

Golden Rule Mission
178 South Main Street
Helper, UT 84526
(435) 472-2631

Southwest Center

Canyon Creek Women's Crisis Center
Cedar City, UT 84770
(435) 628-1325

Care Share Administrative Office
Food Bank & Temporary Shelter
140 East 400 South
Cedar City, UT 84720
(435) 586-5142

Care and Share of Dixie
Food Bank & Temporary Shelter
131 North 300 West
St. George, UT 84770
(435) 628-1325

Dove Center for Women in Crisis
St. George, UT
(435) 628-1204

Valley Mental Health – Salt Lake

Counseling:
Valley Mental Health Storefront
550 West 700 South
Salt Lake City, UT 84101
(801) 537-7537

Shelter &/or Showers:
Single Woman's / Single Men's
210 South Rio Grande (455 West)
Salt Lake City, UT
(801) 359-4142

Medical:
Fourth Street Clinic
404 South 400 West
Salt Lake City, UT
(801) 364-0058

Dental:
Salt Lake Donated Dental Services
415 West 400 South
Salt Lake City, UT
(801) 983-0345

Optical:
Fourth Street Clinic
404 South 400 West
Salt Lake City, UT
(801) 364- 0058

Valley Mental Health – Summit

Information and Referral
Phone: 211
http://www.informationandrefer0ral.org/

Valley Mental Health – Tooele

Information and Referral
Phone: 211
http://www.informationandreferral.org/

Wasatch Mental Health

Food and Care Coalition
60 N. 300 West
Provo
(801) 373-1825++666

Community Action
815 S. Freedom Boulevard #100
Provo, UT
(801) 373-8200

Wasatch Mental Health

WATCH Program
750 N. 200 West
Provo, UT 84601
(801) 373-4766

Weber Human Services

Ogden Rescue Mission
3920 Wall
Ogden, UT 84405
(801) 392-9156

St. Ann's
137 W. Binford
Ogden, UT
(801) 621-5036

HOSPITALS AND CLINICS

Bear River Mental Health

Brigham Community Hospital
950 S. 500 W.
Brigham City, UT 84320
(435) 734-9471

Logan Regional Hospital
1400 N. 500 E.
Logan, UT 84341
(435) 752-2050

Central Utah Counseling

Mountain View Hospital
1000 East 100 North
Payson, UT 84651
(801) 465-7000

Sevier Valley Hospital
1100 North Main St.
Richfield, UT 84701
(801) 896-8271

Davis Behavioral Health

Lakeview Hospital
630 E. Medical Drive
Bountiful, UT 84010
(801) 299-7387

Free Health Clinic
939 North Fairfield Road
Layton, UT 84041
(Open Tuesday and Thursday from 5:00 pm to 7:00 pm)

Four Corners Community Behavioral Health

Allen Memorial Hospital
719 W 400 N
Moab, UT 84532
(435) 259-7191

Castleview Hospital
300 North Hospital Drive
Price, UT 84501
(435) 637-4800

Northeastern Counseling Center

Ashley Valley Medical Center
151 W. 200 N
Vernal, UT 84078
(435) 789-3342

Uintah Basin Medical Center 250 West 300 North (75-2) Roosevelt, UT 84066
(435) 722-4691

San Juan Counseling Center

San Juan Hospital
364 West 100 North
Monticello, UT 84535
(435) 587-2116

Southwest Center

Dixie Regional Medical Center
Behavioral Inpatient Unit
544 South 400 East
St. George, Utah 84770
(435) 688-4000

Southwest Center Outpatient
Beaver County
757 N. Main
PO Box 1485
Beaver, UT 84713
(435) 438-5537
Emergency (435) 438-2862

Southwest Center Outpatient
Garfield County
609 N. Main #4
PO Box 579
Panguitch, UT 84759
(435) 676-8176
Emergency (435) 676-2411

Southwest Center Outpatient
Iron County
245 East 680 South
Cedar City, UT 84720
(435) 867-7654

Southwest Center Outpatient
Kane County
310 South 100 East, Suite 11
Kanab, UT 84741
(435) 644-4520
Emergency (435) 644-2349

Southwest Center Outpatient
Washington County
474 West 200 North
St. George, UT 84770
(435) 634-5600

Valley Mental Health – Salt Lake

Cottonwood Medical Center
5770 S. 300 E.
Murray, UT 84107
(801) 262-3461

LDS Hospital
8th Avenue & C Street
Salt Lake City, UT 84143
(801) 321-1100

Pioneer Valley Hospital
3460 S. Pioneer Parkway
West Valley City, UT 84120
(801) 964-3100

St. Mark's Hospital
1200 E. 3900 S.
Salt Lake City, UT 84124
(801) 268-7111

University of Utah Medical Center
50 North Medical Drive
Salt Lake City, UT 84132
(801) 581-2121

Valley Mental Health - Summit

Information and Referral
Phone: 211
http://www.informationandreferral.org/

Valley Mental Health – Tooele

Information and Referral
Phone: 211
http://www.informationandreferral.org/

Wasatch Mental Health

American Fork Hospital
1100 East 170 North
American Fork, UT 84003
(801) 756-6001

Mountain View Hospital

1000 E. 100 North
Payson, UT
(801) 465-7000

Orem Community Hospital
331 N. 400 West
Orem, UT
(801) 224-4080

Timpanogos Regional Hospital
750 W. 800 North
Orem, UT
(801) 714-6000

Utah Valley Regional Medical Center
1034 N. 500 W.
Provo, UT 89604
(801) 373-7850, (801) 375-4673

Weber Human Services

McKay Dee Hospital
4401 Harrison
Ogden, UT 84403
(801) 627-2800

Ogden Regional Medical Center
5475 S. 500 E.
Ogden, UT 84401
(801) 479-2111

Midtown Community Health Center
670 28th
Ogden, UT 84403
(801) 393-5355

UMAP
2540 Washington Blvd. Suite 122
Ogden, UT 84401
(801) 626-3670

McKay Porter Clinic
4403 Harrison Suite A-700
Ogden, UT
(801) 387-5300

HOUSING/IN-HOME SKILLS PROGRAMS

(***all referrals must be coordinated through the CMHC***)

Bear River Mental Health

Bear River Mental Health Group Home
1115 North Main
Logan, UT 84341
(435) 753-7053

Gateway Apartments
1123 North Main
Logan, UT 84321
(435) 753-7053

Snow Park Village
500 North Main
Brigham City, UT 84302
(435) 723-3176

Alpine Gardens
255 West 300 North
Logan, UT 84321
(435) 753-7053

Box Elder Commons
120 E. 400 N.
Brigham City, UT 84302
(435) 723-2459

Central Utah Counseling

Central Utah Residential Unit
125 South State
Mt. Pleasant, UT 84647
(435) 462-2421

Nephi Residential
940 North Main
Nephi, UT 84648

(435) 462-2421

Triangle Apartments
1st North 1st West
Mt. Pleasant, UT 84647
(435) 462-2421

Davis Behavioral Health

Barnes North
1355 East 1300 South
Clearfield, UT 84015
(801) 774-6580

Barnes South
404 West Center Street
Bountiful, UT 84010
(801) 774-7060

SunValley Apartments
2955 North 1400 West
Layton, UT
(801) 774-6580

Pepperidge
1080 South 1500 East
Clearfield, UT
(801) 774-6580

Four Corners Community Behavioral Health

Willows Supported Housing
48 N Shields
Moab, UT 84532
(435) 259-3155

Cottonwood Four Plex
525 North Cottonwood
Price, UT 84501
(435) 637-7200

Friendship House
496 East 100 North
Price, UT 84501
(435) 637-7200

Ridgeview Apartments
520 Kane Creek
Moab, UT 84532
(435) 259-6131

Northeastern Counseling Center

Vernal Four-Plex
56 East 400 South
Vernal, UT 84078
(435) 789-6300

Roosevelt Four-Plex
178 West 100 South
Roosevelt, UT 84066
(435) 789-6300

Southwest Center

Mt. View Adult Residential
Treatment Program
33 N. 300 E.
Cedar City, UT 84720
(435) 586-6654

Men's Duplex
129 East 600 South
St. George, UT 84770
(435) 674-9431

Women's Duplex
1154 West 540 North #3
St. George, UT 84770
(435) 674-9431

Cedar City Duplex
112 Robbers Roost
Cedar City, UT 84720
(435) 674-9431

Canyon Pointe
474 West 200 North
St. George, UT 84770
(435) 674-9431

Kensington Apartments
474 West 200 North
St. George, UT 84770
(435) 674-9431

Summit Pointe
474 West 200 North
St. George, UT 84770
(435) 674-9431

Valley Mental Health

Alliance House Apartments
1805 South Main
Salt Lake City, UT 84115
(801) 486-5012

Independent Living Program
1141 East 3900 South
Salt Lake City, UT 84124
(801) 284-4908

Ivy House
1076 East 200 South
Salt Lake City, UT 84111
(801) 284-4900

Janes East
717 East Springville Dr.
Salt Lake City, UT 84124
(801) 284-4900

Oquirrh Ridge East
6854 South 700 East
Murray, UT 84047
(801) 565-1267

Oquirrh Ridge West
4980 West 4700 South
West Valley City, UT 84120
(801) 288-8400

Outmovement Program
3610 South 10th West
West Valley City, UT 84119
(801) 288-8400

Safe Haven & Home Front
550 West 7th South
Salt Lake City, UT 84101
(801) 537-7537

Storefront Shelter Plus Care Program
550 West 700 South
Salt Lake City, UT 84101
(801) 537-7537

Valley Crossroads
4860 West 4700 South
West Valley City, UT 84118
(801) 288-8400

Valley Home Front
107 South 800 West
Salt Lake City, UT
(801) 537-7537

Valley Horizons
3133 S. 3600 W.
West Valley City, UT 84119
(801) 284-4908

Valley Meadows
c/o Tooele County Housing Authority
118 East Vine
Tooele, UT 84074
(435) 882-7875

Valley Plaza
280 East 600 South
Salt Lake City, UT 84111
(801) 538-2069

Valley Villa
1878 South Main
Salt Lake City, UT 84115
(801) 486-5012

Valley Woods
3610 South 10th West

West Valley City, UT 84119
(801) 288-8400

Voucher Program
1141 East 3900 South
Salt Lake City, UT 84124
(801) 284-4900

Wasatch Mental Health

Alpine House
156 South 300 West
Provo, UT 84601
(801) 373-7443

Springville
280 East 300 North
Springville, UT
(801) 373-7443

Provo City Duplex
186 North 600 West
Provo, UT 84604
(801) 373-7440

Shelter Plus Care Program
605 East 600 South
Provo, UT 84606
(801) 373-7440

Independent Living Program
605 East 500 South
Provo, UT 84606
(801) 373-7440

Weber Human Services

Women's Residential
2695 Childs
Ogden, UT 84401
(801) 625-3645

Men's Residential
2765 Madison
Ogden, UT 84401
(801) 625-3645

Women's Group Home
2630 Monroe
Ogden, UT
(801) 625-3734

Men's Group Home
380 30th St.
Ogden, UT
(801) 625-3734

PAAG, Inc
2568 Washington Blvd Suite 101
Ogden, UT 84401
(801) 621-2215

Subsidized Housing:
PAAG, Inc
2568 Washington Blvd Suite 101
Ogden, UT 84401
(801) 621-2215

Kier Corporation
3710 Quincy
Ogden, UT 84403
(801) 621-0330

St. Benedicts Manor
3000 Polk
Ogden, UT 84403
(801) 393-6767

IMD Alternative
864 24th Street
Ogden, UT 84401
(801) 625-3700

Bramwell Court
2568 Washington Blvd. #100
Ogden, UT 84401
Page: (801) 621-2214
Liaison: (801) 625-3700

Royal Hotel
2522 Wall
Ogden, UT 84401

(801) 625-3700

Men's Group Home
354 30th Street
Ogden, UT 84401
(801) 625-3700

Women Triplex
2630 Monroe Blvd.
Ogden, UT 84401
(801) 625-3700

Jail Diversion Program
2127 Lincoln
Ogden, UT 84401
(801) 625-3700 (3661)

The Annex
368 30th Street
Ogden, UT 84401
(801) 625-3700

INPATIENT/CRISIS SERVICES AND/OR RESIDENTIAL PROGRAMS

Bear River Mental Health

Bear River Mental Health Group Home
1115 North Main
Logan, UT 84341
(435) 753-7053

Central Utah Counseling

Utah Valley Regional Medical Center
1034 North 500 West
Provo, UT 84605
(801) 357-7376

Davis Behavioral Health

Davis Behavioral Health
Comprehensive Treatment Unit
2250 N. 1700 W.
Layton, UT 84041
(801) 779-3001

Addictions Treatment Unit
2250 N. 1700 West
Layton, UT 84041
(801) 776-1726

Alcohol Recovery Center
2250 N. 1700 West
Layton, UT 84041
(801) 776-4188

Women's Recovery Center
2250 N. 1700 West
Layton, UT 84041
(801) 779-9228

Four Corners Community Behavioral Health

Utah Valley Regional Medical Center
1034 North 500 West
Provo, UT 84605
(801) 357-7376

Northeastern Counseling Center

Uintah County
1140 W. 500 S.
P.O. Box 1908
Vernal, UT 84078
(435) 789-6300

Duchesne County
285 West 800 South
Roosevelt, UT 84066
(435) 725-6300

Daggett County

95 North 100 West
Manila, UT 84046
(435) 784-3006

San Juan Counseling Center

Utah Valley Regional Medical Center
1034 North 500 West
Provo, UT 84605
(801) 357-7376

Southwest Center

Southwest Center (Crisis)
Washington County
474 W. 200 N.
St. George, UT 84770
(435) 634-5600

Southwest Center (Crisis)
Iron County
245 E. 680 S.
Cedar City, UT 84720
(435) 867-7654

Horizon House Adult Substance Abuse Treatment
54 North 200 East
Cedar City, UT 84720
(435) 586-2515

Southwest Center Eagle Quest
(Adolescent Residential & Day Treatment for Sex Offenders)
Cedar City, UT 84720
(435) 865-7312

Valley Mental Health – Salt Lake

Valley Mental Health
Community Treatment Program (CTP)
3944 South 400 East
Murray, UT 84107
(801) 261-1442

University of Utah Medical Center - 5-West
50 North Medical Drive
Salt Lake City, UT 84132
(801) 581-2811

University of Utah
Neuropsychiatric Institute
501 Chipeta Way
Salt Lake City, UT 84108
(801) 583-2500

Valley Mental Health – Summit

Valley Mental Health
1753 Sidewinder #S200
Park City, UT 84060
(435) 649-9079

Valley Mental Health
Community Treatment Program (CTP)
3944 South 400 East
Murray, UT 84107
(801) 261-1442

Valley Mental Health – Tooele

Valley Mental Health
100 South 1000 West
Tooele, UT 84074
(435) 843-3520

Valley Mental Health
Community Treatment Program (CTP)
3944 South 400 East
Murray, UT 84107
(801) 261-1442

Wasatch Mental Health

Wasatch Mental Health
24 Hour Crisis Services
(801) 373-7393

Utah Valley Regional Medical Center
1034 North 500 West
Provo, UT 84605
(801) 357-7376

UVRMC Inpatient Services
1034 North 500 West
Provo, UT 84605
(801) 357-7376

Weber Human Services

McKay Dee Hospital
4401 Harrison
Ogden, UT 84403
(801) 627-2800

LEGAL SERVICES

Statewide

Disability Law Center
205 North 400 West
Salt Lake City, Utah 84103
(801) 363-1347 Voice
1-800-662-9080 Voice
1-800-550-4182 TTY
(801)-924-3185 TTY
http://www.icdri.org/legal/utahpadd.htm

Southwest Center

Disability Law Center
2111 N. Main #7
Cedar City, UT 84720
(435) 586-2773
(800) 824-9311

Utah Legal Services
965 S. Main #3
Cedar City, UT 84720
(435) 586-2571
(800) 662-1772

Valley Mental Health – Salt Lake

Disability Law Center
205 North 400 West
Salt Lake City, Utah 84103
(801) 363-1347
1-800-662-9080

Utah Legal Services
254 West 400 South, Suite 200
Salt Lake City, Utah 84101
(801) 328-8891
(800) 662-4245

Valley Mental Health – Summit

Disability Law Center
205 North 400 West
Salt Lake City, Utah 84103
(801) 363-1347
1-800-662-9080

Valley Mental Health – Tooele

Disability Law Center
205 North 400 West
Salt Lake City, Utah 84103
(801) 363-1347
1-800-662-9080

Wasatch Mental Health

Disability Law Center
548 East 300 South, Suite 106
American Fork, UT 84003
(801) 492-7561 Voice/TTY

Utah Legal Services
455 N. University Ave. #300
Provo, UT
(801) 374-6766

Weber Human Services

Utah Legal Services

893 24th St., Suite 300
Ogden, UT 84401
(801) 394-9431

PUBLIC HOUSING AUTHORITIES

Bear River Mental Health

Bear River Regional Housing Authority
170 North Main Street
Logan, UT 84321
(435) 752-7242

Logan City Housing Authority
170 North Main Street
Logan, UT 84321
(435) 752-7242

Davis Behavioral Health

Davis County Housing Authority
352 South 200 West, Suite 11
Farmington, UT 84025
(801) 451-2587

Four Corners Community Behavioral Health

Carbon County Housing Authority
251 South 1600 East
Price, UT 84501

Emery County Housing Authority
75 E Main
Castle Dale, UT 84513
(435) 381-2902

Grand County Housing Authority
1075 S Hwy 191
Moab, UT 84532
(435) 259-5891

Northeastern Counseling Center

Uintah Basin Assistance Council
58 East 100 North (83-11)
Roosevelt, UT 84066
(435) 722-3952

Myton City Housing Authority
58 East 100 North (83-11)
Roosevelt, UT 84066
(435) 722-3952

Southwest Center

Cedar City Housing Authority
364 South 100 East
Cedar City, UT 84720
(435) 586-8462

St. George Housing Authority
975 North 1725 West, #101
St. George, UT 84770
(435) 628-3648

Beaver City Housing Authority
P.O. Box 1670
Beaver, UT 84713
(435) 438-2935

Valley Mental Health – Salt Lake

Housing Authority of Salt Lake City
1776 South West Temple
Salt Lake City, UT 84115
Phone: 801-487-2161

Housing Authority of the County of Salt Lake
3595 South Main Street
Salt Lake City, UT 84115
(801) 284-4420

West Valley City Housing Authority
3600 South Constitution Blvd.

West Valley City, UT 84119
Phone: 801-966-3600

Valley Mental Health – Summit

Information and Referral
Phone: 211
http://www.informationandreferral.org/

Valley Mental Health – Tooele

Tooele County Housing Authority
118 East Vine
Tooele, UT 84074
(435) 882-7875

Wasatch Mental Health

Provo City Housing Authority
650 W. 100 North
Provo, UT
(801) 852-7080

Housing Authority of Utah County
240 E. Center St.
Provo, UT
(801) 373-8333

Weber Human Services

Ogden Housing Authority
2661 Washington Suite 102
Ogden, UT 84401
(801) 627-5851

Weber County Housing Authority
2380 Washington Blvd., Suite 240
Ogden, UT 84401
(801) 399-8764

REHABILITATION SERVICES

Bear River Mental Health

Brigham City Office
695 South Main, Suite #4
Brigham City, Utah 84302
(435) 734-9408
1-800-559-9408 Voice/TDD

Logan Office
115 W. Golf Course Road #D
Logan, Utah 84321-5984
(435) 787-3480
1-800-560-9766 Voice/TDD

Central Utah Counseling

Vocational Rehabilitation
Manti Office
55 South Main
Manti, UT
(435) 835-0750

Davis Behavioral Health

South Davis Office
55 South Main Street #2
Bountiful, Utah 84010
(801) 296-1293 Voice/TTY

Layton Office
2984 North 400 West, Suite A
Layton, Utah 84041-1344
(801) 776-5951 Voice/TDD
(801) 773-7113

Clearfield Office
1350 East 1450 South
Clearfield, Utah 84015
(801) 776-7324 Voice/TTY

Four Corners Community Behavioral Health

Vocational Rehabilitation
662 West Price River Drive
Price, UT 84501
(435) 636-2820

Grand County Voc-Rehab
125 W 200 S #110
Moab, UT 84532
(435) 259-4635

Northeastern Counseling Center

Vocational Rehabilitation
Vernal Office
1680 West Hwy 40, #106D
Vernal, Utah 84078-4135
(435) 789-0273
1-800-286-0273 Voice/TDD

Vocational Rehabilitation
Roosevelt Office
1100 East Lagoon
Roosevelt, Utah 84066-3099
(435) 722-3563 Voice/TDD

San Juan Counseling Center

Vocational Rehabilitation
Blanding Office
212 North Main Street
Blanding, Utah 84511
(435) 678-2511
1-800-531-9912 Voice/TDD

Southwest Center

Vocational Rehabilitation
(Utah State Office of Rehabilitation)
410 N. Main
Cedar City, UT 84720
(435) 586-9995

Vocational Rehabilitation
(Utah State Office of Rehabilitation)
1067 E. Tabernacle #10
St. George, UT 84770
(435) 673-5091

Valley Mental Health – Salt Lake

Utah State Office Of Rehabilitation
- Administration Office
250 East 500 South
Salt Lake City, Utah 84111
(801) 538-7530/1-800-473-7530

Salt Lake Downtown District
660 South 200 East, Suite 400
Salt Lake City, Utah 84111
(801) 238-4560

Redwood Office
1595 West 500 South
Salt Lake City, Utah 84104
(801) 887-9500 Voice/TDD

Valley West District
2964 West 4700 South, Ste 102
Salt Lake City, Utah 84118
(801) 957-8200 Voice/TDD

South Salt Lake District
5020 South State Street
Salt Lake City, Utah 84107
(801) 267-5600 /1-800-625-7519
Voice/TDD

Valley Mental Health – Summit

Information and Referral
Phone: 211
http://www.informationandreferral.org/

Valley Mental Health – Tooele

Tooele Office
161 North Main
Tooele, Utah 84074-2141

(435) 882-1086/1-800-734-1086
Voice/TDD

Wasatch Mental Health

Vocational Rehabilitation
150 E. Center #3200
Provo, UT
(801) 374-7724

Weber Human Services

Vocational Rehab
1140 36th Suite 150
Ogden, UT 84401
(801) 395-7020

Vocational Rehab
150 N. Washington Blvd.
Ogden, UT 84404
(801) 395-6310

SOCIAL SECURITY OFFICES

Salt Lake City Office
202 West 400 South
Salt Lake City, Utah 84101
(800) 772-1213
(801) 524-4115
http://www.ssa.gov/

Bear River Mental Health

324 25th Street
Ogden, UT 84401
(800) 772-1213
(801) 625-5641

Central Utah Counseling

Provo Office
485 North Freedom Blvd.
Provo, UT 84601
(801) 377-5651
(800) 772-1213

Davis Behavioral Health

Salt Lake City Office
202 West 400 South
Salt Lake City, UT 84101
(800) 772-1213
(801) 524-4115

Four Corners Community Behavioral Health

Provo Office
485 North Freedom Blvd.
Provo, UT 84601
(801) 377-5651
(800) 772-1213

Northeastern Counseling Center

Provo Office
485 North Freedom Blvd.
Provo, UT 84601
(801) 377-5651
(800) 772-1213

Southwest Center

Cedar City Office
82 N. 100 E.
P.O. Box 769
Cedar City, UT
(435) 586-6554

St. George Office
180 N. 200 E. Suite #210
St. George, UT
(435) 674-9226

Valley Mental Health – Salt Lake

Salt Lake City Office
202 West 400 South
Salt Lake City, Utah 84101

(800) 772-1213
(801) 524-4115

Murray Office
6065 South 300 East
Murray, Utah
(800) 772-1213
(801) 268-1060

Valley Mental Health – Summit

Salt Lake City Office
202 West 400 South
Salt Lake City, Utah 84101
(800) 772-1213
(801) 524-4115

Valley Mental Health – Tooele

Salt Lake City Office
202 West 400 South
Salt Lake City, Utah 84101
(800) 772-1213
(801) 524-4115

Wasatch Mental Health

Provo Office
485 North Freedom Blvd.
Provo, UT 84601
(801) 377-5651
(800) 772-1213

Weber Human Services

Ogden Office
324 25th
Ogden, UT 84401
(801) 625-5641

SUBSTANCE ABUSE SERVICES

Bear River Mental Health

Bear River Health Department
Substance Abuse Program
655 East 1300 North
Logan, UT 84321
(435) 752-3730

Local Substance Abuse Authority
Board of Commissioners
95 West 100 South
Logan, UT 84321

Central Utah Counseling

Central Utah Counseling Center
255 West Main St.
Mt Pleasant, UT 84647
(435) 462-2416

Local Substance Abuse Authority
Central Utah MH/SA Authority
Board
245 South 400 East
Nephi, UT 84684

Davis Behavioral Health

Davis Behavioral Health
291 South 200 West
Farmington, UT 84024
(801) 451-7799

Substance Abuse Services
2250 North 1700 West
Layton, UT 84041
(801) 773-7060

Local Substance Abuse Authority
Davis County Board of
Commissioners
PO Box 618
Davis County Courthouse
Farmington, UT 84025

Four Corners Community Behavioral Health

Four Corners Community
Behavioral Health
Price Office
575 East 100 South
Price, UT 84501
(435) 637-2358

Four Corners Community
Behavioral Health
Castle Dale Office
PO Box 387
Castle Dale, UT 84513
(435) 381-2432

Four Corners Community
Behavioral Health
Moab Office
198 East Center
Moab, UT 84532
(435) 259-6131

Local Substance Abuse Authority
Carbon County Courthouse
120 East Main Street
Price, UT 84501

Northeastern Counseling Center

Northeastern Counseling Center
1140 West 500 South
Vernal, UT 84078
(435) 789-6300

Local Substance Abuse Authority
559 North 1700 West
Vernal, UT 84078

San Juan Counseling Center

San Juan Counseling Center
356 South Main St.
Blanding, UT 84511
(435) 678-2992

Local Substance Abuse Authority
San Juan MH/SA Special Service
District Board
171 North 200 West
Blanding, UT 84511

Southwest Center

Southwest Center
474 West 200 North
St. George, UT 84770
(435) 634-5600

Local Substance Abuse Authority
Southwest Center Authority Board
474 West 200 North
St. George, UT 84770

Horizon House
Southwest Center Substance Abuse
Treatment
54 N. 200 E.
Cedar City, UT 84720
(435) 586-2515

Alcoholics Anonymous/Al-Anon
(435) 674-4791
Watch the Spectrum newspaper for
local meetings & times.

LDS 12-Step Substance Abuse
Recover Program
(435) 628-3535
Call for meeting locations & times.

Paiute Indian Tribe of Utah Health
& Social Services
440 Paiute Dr.
Cedar City, UT 84720
(435) 586-5914

Southwest Center
Beaver County
757 N. Main
P.O. Box 1485

Beaver, UT 84713
(435) 438-5537
Emergency (435) 438-2862

Southwest Center
Iron County
245 E. 680 S.
Cedar City, UT 84720
(435) 867-7654

Southwest Center
Washington County
474 W. 200 N.
St. George, UT 84770
(435) 634-5600

Valley Mental Health – Salt Lake

Utah Department of Human Services - Division of Substance Abuse & Mental Health
120 North 200 West
Salt Lake City, UT 84103
(801) 538-4270

Salt Lake County Division of Substance Abuse Services
2001 South State Street #S2300
Salt Lake City, Utah 84190
(801) 468-2009

Local Substance Abuse Authority
Salt Lake County Authority
2001 South State #N2100
Salt Lake City, Utah 84190

Valley Mental Health
Alcohol and Drug
5965 South 900 East
Salt Lake City, Utah 84121
(801) 263-7225

Valley Mental Health – Summit

Local Substance Abuse Authority
Summit County Commission
2685 North State Highway 32
Kamas, Utah 84036

Valley Mental Health
1753 Sidewinder #S200
Park City, UT 84060
(435) 649-9079

Valley Mental Health – Tooele

Valley Mental Health
100 South 1000 West
Tooele, UT 84074
(435) 843-3520

Wasatch Mental Health

Foothill Treatment Center
3281 North Main
Spanish Fork, Utah 84660
(801) 370-8912

Utah County Division of Human Services
100 East Center Street, #3300
Provo, UT 84606
(801) 370-8427

Local Substance Abuse Authority
Utah County Commission
100 East Center Street, Suite 2300
Provo, UT 84606

Wasatch County Center for Alcohol and Drug Services
55 South 500 East
Heber, UT 84032
(435) 654-3003

Local Substance Abuse Authority
Wasatch County Commission
25 North Main Street
Heber, UT 84032

Weber Human Services

Weber Human Services
237 26th St.
Ogden, UT 84401
(801) 625-3700

Local Substance Abuse Authority
Weber Human Services Board
2650 Lincoln Avenue, Rm.311
Ogden, UT 84401

Statewide Local Authority

Utah Behavioral Healthcare Network, Inc.
2735 East Parley's Way, Suite 205
Salt Lake City, UT 84109
(801) 487-3943

UTAH DEPARTMENT OF HEALTH

Utah Department of Health
288 N. 1460 S.
Salt Lake City, Utah 84114
(801) 538-6101
http://health.utah.gov/

Davis Behavioral Health

Department of Health
915 North 400 West, Suite 201
Layton, UT 84041
(801) 444-2900

Four Corners Community Behavioral Health

Southeastern Utah Health Department
28 South 100 East
Price, UT 84501
(435) 637-3671

Southeastern Utah Health Department
471 South Main
Moab, UT 84532
(435) 259-5602

Southwest Center

Bureau of Eligibility Services
Beaver County (located in Beaver Valley Hospital)
P.O. Box 1482
Beaver, UT 84713
(435) 438-7162
(800) 310-6949

Bureau of Eligibility Services
Iron County
106 N. 100 E.
Cedar City, UT 84720
(435) 865-5700
(800) 310-6949

Bureau of Eligibility Services
Garfield & Kane Counties
(located in Garfield Memorial Hospital)
P.O. Box 63
Panguitch, UT 85759
(435) 676-8866
(800) 310-6949

Bureau of Eligibility Services
Washington County
619 S. Bluff St. Suite 4A
St. George, UT 84770
(435) 688-0489
(800) 310-6949

Valley Mental Health – Salt Lake

Utah Department of Health
288 N. 1460 S.
Salt Lake City, Utah 84114
(801) 538-6101

UTAH DEPARTMENT OF HUMAN SERVICES

Utah Department of Human Services
120 North 200 West
Salt Lake City, UT 84103
(801) 538-4171
http://www.dhs.state.ut.us/

State Abuse and Neglect Numbers

Salt Lake County:
(801) 264-7669
Statewide:
(800) 371-7897

Bear River Mental Health

Bear River Health Dept.
Division of Substance Abuse
655 East 1300 North
Logan, Utah 84341
(435) 752-3730

Adult Protective Services
115 West Golf Course Rd
Suite B
Logan, Utah 84321
(435) 787-3425

Bear River Health Dept.
Div. of Health Promotions
655 East 1300 North
Logan, Utah 84341
(435) 752-1799

Child & Family Services
Logan Office
115 W. Golf Course Rd., Ste B
Logan, UT 84321-5951
(435) 787-3400

Central Utah Counseling

Substance Abuse
656 North Main Street
Nephi, Utah 84648
(435) 623-1456
or (435) 623-1520

Adult Protective Services
201 East 5th North
Richfield, Utah 84701
(435) 896-1290

Mental Health
Central Utah Mental Health
Nephi Office
656 North Main
Nephi, Utah 84648
(435) 623-1456

Services for People with Disabilities
Nephi Office
54 North Main Street
Nephi, UT 84648
(435) 623-2431

Adult Protective Services
50 South Main
Manti, Utah 84642
(435) 835-5650

Services for People with Disabilities
Manti Office
50 South Main St. #5
Manti, UT 84642
(435) 835-0795

Davis Behavioral Health

Women's Recovery Center
2250 North 1700 West
Layton, Utah 840410
(801) 779-9228

Intensive Outpatient Program

860 South State Street
Clearfield, Utah 84015
(801) 776-6303

Outreach Center
904 S. State Street
Clearfield, Utah 84015
(801) 776-6303

Davis Behavioral Health
470 East Medical Dr.
Bountiful, Utah 84010
(801) 298-3446

Services for People with Disabilities
Clearfield Office
1350 East 1450 South
Clearfield, UT 84015
(801) 776-7300

Adult Protective Services
1350 East 1450 South
Clearfield, Utah 84015
(801) 776-7300

Child & Family Services
Bountiful Office
528 West 100 North
Bountiful, UT 84101
(801) 397-7640

Clearfield Office
1350 East 1450 South
P.O. Box 825
Clearfield, UT 84015-1611
(801) 776-7300

Four Corners Community Behavioral Health

Division of Child and Family Services
475 West Price River Drive
Price, UT 84501
(435) 637-0890

Human Services Department
690 E Main
Castle Dale, UT 84513
(435) 381-4730

Adult Protective Services
475 West Price River Drive
Suite 262
Price, Utah 84501-2858
(435) 636-2394

Child & Family Services
Eastern Region Administration Office
475 West Price River Drive,
Suite152
Price, UT 84501-2838
(435) 636-2360

Child & Family Services
Moab Office
1165 South Highway 191, Suite 1
P.O. Box 1030
Moab, UT 84532-3062
(435) 259-3720

Adult Protective Services
1165 So. Highway 191, Suite 1
Moab, Utah 84532
(435) 259-3729

Northeastern Counseling Center

Child & Family Services
Roosevelt Office
140 West 425 South, Ste 330-15
Roosevelt, UT 84066-3701
(435) 722-6550

Substance Abuse
510 West 200 North
Box 59-12
Roosevelt, Utah 84066
(435) 722-2855

Mental Health
Uintah Basin Counseling
559 North 1700 West
PO Box 1908
Vernal, Utah 84078-5908
(435) 789-6300

San Juan Counseling Center

Child & Family Services
Blanding Office
522 North 100 East
Blanding, UT 84511
(435) 678-1491

Monticello Office
16 East 300 South
P.O. Box 610
Monticello, UT 8453
(435) 587-2016

Southwest Center

Adult Protective Services Hotline
(800) 371-7897

Child Protective Services Hotline
(800) 953-3842

Beaver County
Child & Family Services
875 North Main Street
Beaver, UT 84713
(435) 438-2280

Garfield County
Child & Family Services
665 North Main Street
P.O. Box 395
Panguitch, UT 84759-0395
(435) 676-8867

Iron County
Child and Family Services
106 North 100 East
Cedar City, UT 84720
(435) 865-5600

Adult Protective Services
106 North 100 East
Cedar City, Utah 84720
(435) 865-5660

Kane County
Child & Family Services
310 South 100 East
Kanab, UT 84741
(435) 644-4530

Washington County
Child & Family Services
377 East Riverside Drive
St. George, UT 84790
(435) 652-2960

Valley Mental Health – Salt Lake

Department of Human Services
120 North 200 West, Suite 225
Salt Lake City, UT 84103-1500
(801) 538-4100

Valley Mental Health – Summit

Department of Human Services
1764 Prospector Square
Park City, UT 84060
(435) 645-8703

Valley Mental Health – Tooele

Department of Human Services
305 North Main Street
Tooele, UT 84074
(435) 833-7355

Wasatch Mental Health

Utah County Division of Human Services
100 East Center Street,
Ste. 3300

Provo, Utah 84606
(801) 370-8427

Weber Human Services

Department of Human Services
2540 Washington Blvd.
Ogden, UT
(801) 626-3300

UTAH DEPARTMENT OF WORKFORCE SERVICES

http://jobs.utah.gov/

Bear River Mental Health

Logan - Bridgerland
(Bridgerland Applied Technology Center)
1301 N. 600 W.
Logan, UT 84321
(435) 750-3205

Logan
446 North 100 West
Logan, UT 84321
(435) 792-0300

Central Utah Counseling

Delta Employment Center
44 S. 350 E.
Delta, UT 84624
Phone: (435) 864-3860

Phone: (435) 864-3860
Fillmore Employment Center
55 West 100 North
Fillmore, UT 84631
Phone: (435) 743-5304

Manti Employment Center
55 South Main, Suite #3
Manti, UT 84642
(435) 835-0720

Nephi Employment Center
625 North Main
Nephi, UT 84648
Phone: (435) 623-1927

Richfield Employment Center
115 East 100 South
Richfield, UT 84701
Phone: (435) 893-0000

Davis Behavioral Health

Department of Work Force Services
1290 East 1450 South
Clearfield, UT 84015
(801) 776-7800

Four Corners Community Behavioral Health

Department of Workforce Services
475 West Price River Drive
Price, UT 84501
(435) 636-2300

Department of Workforce Services
678 East Main
Castle Dale, UT 84513
(435) 381-2432

Department of Workforce Services
457 Kane Creek Blvd
Moab, UT 84532
(435) 719-2600

Northeastern Counseling Center

Roosevelt Employment Center
140 West 425 South 330-13
Roosevelt, UT 84066
(435) 722-6500

San Juan Counseling Center

Blanding Employment Center
544 N. 100 E.
Blanding, UT 84511
(435) 678-1400

Monticello Employment Center
16 E. 300 S.
P.O. Box 517
Monticello, UT 84535
(435) 587-2015

Southwest Center

Department of Workforce Services /
Vocational Rehabilitation
176 E. 200 N.
Cedar City, UT 84720
(435) 865-6530

Department of Workforce Services /
Vocational Rehabilitation
162 N. 400 E. Bldg. B
St. George, UT 84770
(435) 674-5627

Beaver Employment Center
875 North Main Street
Beaver, UT 84713
(435) 438-5498

Kanab Employment Center
468 East 300 South
Kanab, UT 84741
(435) 644-8910

Panguitch Employment Center
665 North Main Street
Panguitch, UT 84759
(435) 676-8893

Valley Mental Health – Salt Lake

Salt Lake City Downtown
Employment Center
158 South 200 West
Salt Lake City, UT 84101
(801) 524-9000

Business Services Center
1385 South State Street
Salt Lake City, UT 84111
Toll Free Phone: 1-888-920-WORK
Main phone: 1-801-468-0097

West Valley Employment Center
2750 South 5600 West, Suite A
West Valley City, Utah 84120
(801) 840-4400

Salt Lake City - Metro Employment
Center
720 South 200 East
Salt Lake City, UT 84111
(801) 536-7000

Valley Mental Health – Summit

Park City Employment Center
1846 Prospector Ave.
P.O. Box 680697
Park City, UT 84068-0697
(435) 649-8451

Valley Mental Health – Tooele

Tooele Employment Center
305 North Main Street, Suite 100
Tooele, UT 84074
(435) 833-7310

Wasatch Mental Health

Provo Employment Center
1550 N. 200 W.
Provo, UT 84604
(801) 342-2600

American Fork Employment Center
751 East Quality Drive

Suite 100
American Fork, UT 84003
(801) 492-4500

Spanish Fork Employment Center
1185 North Chappel Dr. Spanish Fork, UT 84660
Phone: (801) 794-6600

Heber City Employment Center
69 North 600 West
Suite C
Heber, UT 84032
Phone: (435) 654-6520

Weber Human Services

Utah Department of Workforce Services
480 27th
Ogden, UT 84401
(801) 626-0300

UTAH STATE HOSPITAL

Utah State Hospital
1300 East Center Street
Provo, UT 84606
(801) 344-4400
http://www.hsush.utah.gov/

VETERANS' SERVICES

Statewide

Salt Lake Regional Office and Care Facilities
550 Foothill Drive
Salt Lake City, UT 84158
Phone: 1-800-827-1000

Central Utah Counseling

Central Valley Medical Center
48 W. 1500 N.
Nephi, UT 84648
(435) 623-3129

Northeastern Counseling Center

Uintah Outpatient Clinic
210 West 300 North
Roosevelt, UT 84066
(435) 722-3971

Southwest Center

Veteran's Health Center Clinic
1067 E. Tabernacle
St. George, UT 84770
(435) 634-7608

Valley Mental Health – Salt Lake

Regional Office and Care Facilities
550 Foothill Drive
Salt Lake City, UT 84158
Phone: 1-800-827-1000

VA Salt Lake City Health Care System
500 Foothill Drive
Salt Lake City, UT 84148
(801) 582-1565

Salt Lake City Vet Center
1354 E. 3300 South
Salt Lake City, UT 84106
(801) 584-1294

Wasatch Mental Health

Orem Outpatient Clinic/Timpanogos Regional Hospital
740 West 800 North, Suite 440
Orem, UT 84057
(801) 235-0953

Provo Vet Center
750 North 200 West, Suite 105,
Provo, UT 84601
(801) 377-1117

Weber Human Services

Ogden Veterans' Clinic
982 Chambers St.
South Ogden, UT 84403
(801) 479-4105

OTHER

Davis Behavioral Health

Utah Food Bank (Family Connection Center)
1449 North 12th West
Layton, UT 84041
(801) 444-2691

Davis County Teen Line
(801) 451-8336

Utah Health Line
1-800-472-4716

Four Corners Community Behavioral Health

Carbon County Food Bank
75 East 400 So
Price, UT 84501
(435) 637-9232

Carbon County Sheriff's Office
240 West Main
Price, UT 84501
(435) 636-3251

Active Re-Entry Community Integration
10 So Fairgrounds Rd
Price, UT 84501
(435) 637-4950

Emergency Assistance
Utah Association of Local Government
375 South Carbon Avenue
Price, UT 84501
(435) 637-5444

Family Support Center
108 North 300 East
Price, UT 84501
(435) 637-0268

Emery County Food Bank and Clothing Exchange
50 So Center
Castle Dale, UT 84513
(435) 381-5410

Emery County Sheriff
1850 N 550 W
Castle Dale, UT 84513
(435) 381-2404

Seekhaven Domestic Violence Shelter
P.O. Box 729
Moab, UT 84532
(435) 259-2229

Grand County Food Bank
58 N 100 S
Moab, UT 84532
(435) 259-6362

Grand County Sheriff's Dept
125 East Center
Moab, UT 84532
(435) 259-8115

Moab City Police
115 W 200 S
Moab, UT 84532
(435) 259-8938

Active Re-Entry
P. O. Box 122
Moab, UT 84532
(435) 259-0245

Southwest Center

Canyon Creek Women's Crisis Center
Cedar City, UT 84770
(435) 628-1325

Care Share Administrative Office
Food Bank & Temporary Shelter
140 East 400 South
Cedar City, UT 84720
(435) 586-5142

Care and Share of Dixie
Food Bank & Temporary Shelter
131 North 300 West
St. George, UT 84770
(435) 628-1325

Dove Center for Women in Crisis
St. George, UT
(435) 628-1204

Valley Mental Health

Utah Information and Referral
Phone: 211
http://www.informationandreferral.org/

Weber Human Services

Catholic Community Services
622 23rd
Ogden, UT 84401
(801) 394-5944

Your Community Connection (YCC)
2261 Adams
Ogden, UT 84401
(801) 394-9456